

NO. 15-1708

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT**

WESTMORELAND COAL COMPANY,

Petitioner,

v.

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
UNITED STATES DEPARTMENT OF LABOR; and PATRICIA F.
FITZWATER (WIDOW OF JACKIE L. FITZWATER),**

Respondents.

**ON PETITION FOR REVIEW FROM THE UNITED STATES
DEPARTMENT OF LABOR, BENEFITS REVIEW BOARD**

**APPENDIX OF PETITIONER
WESTMORELAND COAL COMPANY
VOLUME I OF III**

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In this section, list all of your employment in the coal industry; start with the company for which you first worked and continue in order to the last company for which you worked. If you need more space than is provided in this section, use sheets of plain paper and attach them to this application.

*MONTH AND YEAR

U.S. DEPARTMENT OF LABOR

Employment Standards Administration
Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
Greater Johnstown Tech Park
1 Tech Park Drive, Suite 250
Johnstown, PA 15901-1267
Phone: (814) 619-7777 or 1-800-347-3754
FAX: (814) 610-7790



<u>Miner's Name</u> Jackie L Fitzwater	<u>Designated Responsible Operator</u> Westmoreland Coal Company C/O Wells Fargo Disability Mgm PO Box 3389 Charleston, WV 25333-3389
<u>Claimant's Name</u> Patricia A Fitzwater	
<u>Claimant's Address</u> PO Box 312 Quinwood, WV 25981	<u>Insurer</u> Self-insured thru Westmoreland Coal Company C/O Wells Fargo Disability Mgt PO Box 3389 Charleston, WV 25333-3389
<u>DOL Claim Number</u> XXX-XX-5934 LW C	<u>Date Issued</u> July 15, 2009

SCHEDULE FOR THE SUBMISSION OF ADDITIONAL EVIDENCE

Patricia A Fitzwater filed an application for benefits under the Black Lung Benefits Act on 01/16/2009. We have reviewed the medical evidence developed under 20 C.F.R. § 725.405, and the evidence relevant to coal mine operator liability received under 20 C.F.R. § 725.408. A copy of our "Summary of Medical and Employment Evidence" is attached.

Based on a review of that evidence, we have made the following preliminary conclusions:

1. The claimant would be entitled to benefits if we issued a decision at this time; and
2. The coal mine operator named above is the responsible operator liable for the payment of benefits.

Entitlement

We have reviewed the evidence developed thus far. Our preliminary analysis is that the claimant would be entitled to benefits if we issued a decision at this time. Our analysis of the evidence and the reasons for our conclusions are set forth in the attached Summary. In addition, a "Guide for Submitting Additional Evidence" is attached, explaining the limitations on the quantity of evidence that each party may submit and the types of medical evidence sufficient to establish each element of entitlement.

The responsible operator may respond to this schedule by August 14, 2009, in the manner prescribed in 20 CFR 725.412(b) and either accept or reject the claimant's entitlement to benefits. If the responsible operator does not respond, it will be considered to have contested the claimant's entitlement, and will be liable for the cost of obtaining additional medical and other necessary evidence in the event that the claimant is ultimately found entitled to benefits. The Black Lung Disability Trust Fund will be liable for those costs if the claimant is ultimately found entitled to benefits and this office has not designated a responsible operator.

Director's Exb. No. 27
Consisting of 17 pages.

The claimant and the designated responsible operator listed above may now submit to this office additional medical evidence as to the claimant's entitlement. 20 C.F.R. § 725.414(a). After that evidence is submitted, and we complete any additional processing that we believe may be necessary (which may include an informal conference if all parties are represented and the other requirements of 20 C.F.R. § 725.416 are met), we will issue a proposed decision and order awarding or denying benefits. Any party dissatisfied with that decision and order may request a hearing before the Office of Administrative Law Judges at that time.

The regulations implementing the Black Lung Benefits Act do not require that parties submit any additional medical evidence on entitlement at this point. Instead, parties may wait until the case is referred to the Office of Administrative Law Judges following a request for a hearing. 20 C.F.R. § 725.456(b)(2). If no party submits additional medical evidence on entitlement to our office, we will base our proposed decision and order on the preliminary conclusions stated above.

Any party that wishes to submit medical evidence at this time should mail that evidence to this office, and a copy to the other parties to the claim, in accordance with the following schedule:

September 13, 2009: Evidence that supports each party's position

October 13, 2009: Evidence that responds to evidence submitted by another party

Either party may request that these time periods be extended by showing good cause. A request for extension must be filed before the dates listed above.

Parties should take note that the amount of medical evidence that parties may submit is limited. 20 C.F.R. § 725.414. These limitations are explained in detail in the attached Guide. We encourage you to get advice from an attorney or other qualified representative before submitting any additional evidence. A claimant whose application is finally approved and who uses the services of an attorney in establishing entitlement may be entitled to a reasonable attorney's fee. If the designated responsible operator or the Trust Fund challenge the claimant's entitlement, and is ultimately determined to be liable, the responsible operator or the fund will also be liable for the claimant's attorney's fee. A claimant will not be liable for any attorney's fee if his or her claim is denied. However, a claimant may be liable for a fee if he or she is represented by a person other than an attorney. If a party is represented by a person other than an attorney, the party and the representative should complete and sign the enclosed authorization form (CM-1078), and return it to this office.

Liability

Based on the evidence developed thus far, we have made a preliminary designation of Westmoreland Coal Company as the responsible operator liable for the payment of benefits. Our analysis of that evidence and the reasons for our conclusions are set forth in the attached Summary.

The designated responsible operator may respond to this schedule by August 14, 2009, and accept or reject its designation. If the responsible operator does not respond, it will be deemed to accept its designation and to waive its right to contest its liability in any further proceedings.

The designated responsible operator listed above may now submit to this office additional documentary evidence relevant to liability, and may identify witnesses relevant to liability that the designated responsible operator intends to call if the case is referred to the Office of Administrative Law Judges. 20 C.F.R. § 725.414(b), (c). Absent a showing of extraordinary circumstances, no documentary evidence relevant to liability, or testimony of a witness not identified at this stage of the proceedings, may be admitted into the record once a case is referred to the Office of Administrative Law Judges. 20 C.F.R. § 725.456(b)(1). In addition, the designated responsible operator may no longer submit evidence relevant to its status as a potentially liable operator; operators notified of their potential liability were required to submit all such evidence within 90 days after receiving notification. 20 C.F.R. § 725.408(b)(2).

Accordingly, the designated responsible operator may now submit only that evidence relevant to whether another potentially liable operator should have been designated the responsible operator. Other potentially liable operators may also submit evidence relevant to liability.

Any party that wishes to submit liability evidence or identify liability witnesses, must mail that evidence or identification to this office, and a copy to the other parties to the claim, in accordance with the following schedule:

September 13, 2009: Evidence that supports each party's position

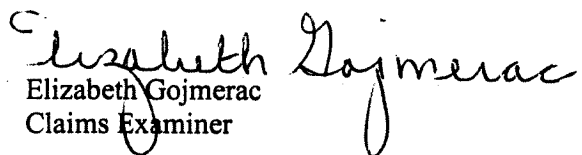
October 13, 2009: Evidence that responds to evidence submitted by another party

Any party may request that these time periods be extended by showing good cause. A request for extension must be filed before the dates listed above.

After any additional evidence is submitted, we may undertake additional processing, including the notification of additional potentially liable operators and the designation of another responsible operator. After we conclude our processing, we will issue a proposed decision and order awarding or denying benefits. Any party dissatisfied with that decision and order may request a hearing before the Office of Administrative Law Judge.

Please contact our office if you need assistance or have questions about the "Schedule for the Submission of Additional Evidence" or any of the other documents we have enclosed.

Sincerely,


Elizabeth Gojmerac
Claims Examiner

Enclosures: Summary of Medical and Employment Evidence
Copy of evidence
Guide for Submitting Additional Evidence
CM-2970

Service (by certified mail): Patricia A Fitzwater; Westmoreland Coal Company; Self-insured thru Westmoreland Coal Company; Douglas A. Smoot, Esquire; Lady H Coal Co Inc; WV CWP Fund

**SUMMARY OF MEDICAL AND EMPLOYMENT EVIDENCE
(SURVIVOR'S CLAIM)**

Date Issued: July 15, 2009	DOL Claim No.: XXX-XX-5934 LW C
Miner's Name: Jackie L Fitzwater	Claimant's Name: Patricia A Fitzwater
Coal Mine Company: Westmoreland Coal Company	Insurance Carrier: Self-insured thru Westmoreland Coal Company

The claimant named above has filed an application under the Black Lung Benefits Act, 30 USC 901 et seq. We have received the medical and employment evidence summarized below. Based on a preliminary review of this evidence, we have concluded that Westmoreland Coal Company is the responsible operator liable for the payment of any benefits in this claim. We have also concluded that the claimant would not be entitled to benefits if we made a decision at this time. A summary of the medical and employment evidence and an analysis of that evidence are set forth below. Copies of all the evidence are attached to this document.

In order to qualify for black lung benefits, you must prove the following facts:

- The deceased individual worked as a coal miner;
- He / She had pneumoconiosis (black lung disease);
- His / Her pneumoconiosis was caused at least in part by exposure to coal mine dust;
- His / Her pneumoconiosis caused, or contributed to, his/her death; and
- You are an eligible dependent of the miner.

Pneumoconiosis "caused" the miner's death if it is the primary reason the miner died. Pneumoconiosis "contributed" to the miner's death if it actually hastened the miner's death. In either case, medical evidence must prove the required relationship between pneumoconiosis and the miner's death.

The evidence which we have received so far would support the following findings:

- (X) The deceased individual worked as a coal miner for 38.5 years;
- (X) He had pneumoconiosis;
- (X) His pneumoconiosis was caused at least in part by exposure to coal mine dust;
- (X) His pneumoconiosis caused, or contributed to, his death; and
- (X) You are an eligible dependent of the miner.

However, the evidence also indicates that:

- () The deceased individual did not work as a coal miner;
- () He / She did not have pneumoconiosis;
- () His / Her pneumoconiosis was not caused at least in part by exposure to coal mine dust;
- () His / Her pneumoconiosis did not cause, or contribute to, his/her death; and
- () You are not an eligible dependent of the miner.

ENTITLEMENT ANALYSIS:

Based on the preliminary analysis of the medical evidence received to date, we have determined the following:

RELATIONSHIP/DEPENDENCY:

The claimant does not claim any dependents. Therefore, the requirements of 20 CFR 725.204 and 725.205 which relate to relationship and dependency are not an issue.

PRESENCE OF PNEUMOCONIOSIS (BLACK LUNG DISEASE):

Autopsy evidence is positive for presence of pneumoconiosis. The autopsy dated 9/28/08 was performed by Dr. M Beatriz Lopes who found Simple Coal Worker's Pneumoconiosis associated with diffuse pulmonary emphysema, anthracotic nodules and mild pulmonary hypertensive changes. The gross and histologic findings in this case are consistent with simple coal worker's pneumoconiosis. The pathologic features include the presence of dust macules and focal emphysema, both of which are required for diagnosis. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules. These findings were not severe enough to diagnose complicated coal worker's pneumoconiosis.

File contains hospital admissions between 1998 to last admission 8/24/08 to 9/24/08 expired. Numerous admissions include Congestive heart failure as primary discharge diagnosis as well as obstructive pulmonary disease.

20 CFR 718.202(a)(2) - established by biopsy/autopsy

The miner's pneumoconiosis was caused by his coal mine employment based upon the presumption in the regulations, 20 CFR 718.203(b) which states: If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. The miner has established at least ten years of coal mine employment. Reasoned medical opinion does not rule out a connection between the disease and coal mine employment. The presumption has not been rebutted.

20 CFR 718.203(b) - established by presumption

DEATH DUE TO BLACK LUNG DISEASE:

The autopsy evidence in the claim does establish that pneumoconiosis caused, contributed to, or hastened death of the miner.

Death Certificate lists cause of death as renal failure, congestive heart failure and infective endocarditis. Statement from Lynn N. Smith, M.D., claimant's primary care physician for over 20 years, indicates that claimant died of complication of his underlying lung disease. That autopsy report documents the presence of his underlying pneumoconiosis. That as a result of this pneumoconiosis, he developed significant cor pulmonale and developed multiple small bowel AV malformations. These vascular lesions resulted in chronic and persistent blood loss through his GI tract. He received in excess of 100 units of blood over the last several years because of this persistent bleeding. Unfortunately the bleeding continued to escalate to the point it was no longer controllable and as a result with complications, he expired. Therefore, evidence does support that pneumoconiosis was contributing factor in the miner's death.

20 CFR 718.205 - death due to pneumoconiosis not established

Based upon the above, the claimant would be entitled to benefits.

EMPLOYMENT EVIDENCE:

38 years coal mine employment has been established from 1956 to 7/1/94 (last day of employment) Last employed by Lady H Coal Co. from 4/8/86 to 7/1/94 (9 yrs 2 months 23 days). Lady H Coal Co., Inc. was insured by WV CWP Fund. Policy was cancelled 3/16/94. Therefore, Lady H Coal Co., Inc. was not insured on the last day of employment.

Prior employment with Westmoreland Coal Co. between 5/28/56 to 3/28/86. (27 years 4 months 26 days). Westmoreland Coal Co. was self insured.

Therefore, Westmoreland Coal Co. is determined to be the designated responsible operator.

LIABILITY ANALYSIS:

Westmoreland Coal Company has been named as the designated responsible operator based upon the following:

1. The designated responsible operator was an operator after 06/30/73 and employed the miner as a miner for not less than one year based upon Social Security earnings, employer statements.
2. The miner's employment with this operator included at least one working day after 12/31/69 based upon Social Security earnings, employer statements.
3. There is a rebuttable presumption that coal mine workers were exposed to coal mine dust during all periods of such employment occurring in or around a coal mine or coal preparation facility. The presumption has not been successfully rebutted.
4. This operator or its insurer is financially capable of assuming liability for the payment of benefits in accordance with 20 CFR 725.494(e).
5. This operator is the operator that most recently employed the miner according to Social Security earnings, employer statements.

A Notice of Claim was received by the potentially liable operator/carrier, Westmoreland Coal Company, on 2/2/09, as evidenced by the signed return receipt from the post office. The potentially liable operator/carrier has failed to timely respond to the Notice of Claim or to timely request an extension of time for response. Therefore, in accordance with 20 CFR 725.408(a)(3), the operator shall not be allowed to contest its liability for the payment of benefits on any of the grounds set forth in the Operator Assertions - 20 CFR 725.408(a)(2).

MEDICAL EVIDENCE

(The first letter of the letter codes with the test dates represent the submitting party for the evidence: "D" stands for Director (the Department of Labor), "R" for designated responsible operator, the employer, and "C" for claimant. The second letter of each code indicates if the evidence is Evidence of record or New evidence developed for this claim.)

MINER: Jackie L Fitzwater

CLAIM NO.: XXX-XX-5934 LW C

X-ray Evidence

X-RAY Film Date	Reread Date	Name of Reader	X-RAY Reader Qualifications	Film Quality	X-RAY Interpretation
08/18/2008	08/18/2008 D-N	Sean Martinez	None	1	No significant internal change in moderate right sides pleural effusion with associated atelectasis
08/28/2008	08/28/2008 D-N	Sean Martinez	None	1	No evidence of focal consolidation; unchanged moderate right sides pleural effusion

Pulmonary Function Study (PFS) Evidence

Date	Physician	Age/ Height	FEV1	MVV	FVC	FEV1 FVC	DISABILITY STANDARDS			Valid?
							FEV1	MVV	FVC	

Arterial Blood-gas (ABG) Evidence

Date	Physician	Resting/ Exercise?	PCO2	PO2	PO2 Disability Standards	Altitude	Valid?

Physical Examination/ Other Evidence

Exam Date	Examining Physician/Qualifications	Findings

09/25/2008 D-N	M Beatriz Lopes -	<p>AUTOPSY REPORT - UNIV. OF VIRGINIA , DEPARTMENT OF PATHOLOGY - FINAL PATHOLOGIC DIAGNOSIS:</p> <p>SIMPLE COAL WORKER'S PNEUMOCONIOSIS -Diffuse pulmonary emphysema -anthracotic nodules -mild pulmonary hypertensive changes</p> <p>CARDIOMEGALY WITH ISCHEMIC CARDIOMYOPATHY -biatrial dilation -right ventricular dilation -left ventricular hypertrophy -multifocal subacute and remote infarcts (microscopic)</p> <p>ATHEROSCLEROSIS -aorta: grade VII/VII -coronary arteries: 40% max occlusion with calcification</p> <p>STATUS POST AORTIC VALVE REPLACEMENT AND PACER PLACEMENT -left chronic fibrotic pleuritis and chronic fibrotic pericarditis</p> <p>The gross and histologic findings in this case are consistent with simple coal worker's pneumoconiosis (SCWP). The pathologic features of SCWP include the presence of dust macules and focal emphysema, both of which are required for diagnosis. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules. The histologic findings were not severe enough to diagnose complicated coal worker's pneumoconiosis which requires gross and microscopic zones of fibrosis that most commonly affect the posterior portions of the upper lobes.</p> <p>Other findings in this case include areas of subacute and chronic myocardial infarction. The decedent's coronary arteries had moderate atherosclerosis, but given his history of repeated GI bleeds, he was prone to bouts of hypotension, which could be responsible for his myocardial ischemia. The decedent also had biatrial and right ventricular dilation, but this is explained by the histologic findings of diffuse emphysema and pulmonary hypertension.</p>
09/24/2008 C-E	K Molly McShane -	<p>DEATH CERTIFICATE - Renal Failure Congestive heart failure Infective endocarditis</p>
08/24/2008 to 09/24/2008 D-N	Christine M Lin -	<p>ADMISSION - UNIV. OF VIRGINIA - Hospital course per problem below:</p> <ol style="list-style-type: none"> 1. GI Bleed 2. Chronic renal failure with progression to end-state renal disease. 3. Cirrhosis. 4. Urinary tract infection 5. spontaneous bacterial peritonitis 6. Infective endocarditis <p>Patient was receiving anticoagulation for numerous reasons. It became clear during his hospital course that therapeutic anticoagulation increased the patient's bleeding from his intestinal AVMs. No balance could be reached. Although the patient's hematocrit did stabilize, his mental status slowly worsened. The family decided to discontinue dialysis and antibiotics and transition the patient to comfort care with the goal of transferring to an in-patient hospice facility closer to home. However, patient passed away on 9/24/08.</p>

08/01/2008 to 08/24/2008 D-N	Robert S. Gibson -	ADMISSION - UNIV OF VIRGINIA - DISCHASRGE DIAGNOSES: 1. Congestive heart failure 2. Mechanical aortic valve infective endocarditis 3. Spontaneous bacterial peritonitis 4. Arteriovenous malformations of the intestines 5. Stroke 6. Atrial fibrillation 7. altered mental status 8. acute kidney injury 9. left subclavian deep vein thrombosis 1
12/31/2008 C-N	Lynn N Smith, M.D.	Statement - Primary Care physician over 20 years. Claimant died from complications of underlying lung disease. Autopsy documents presence of underlying pneumoconiosis. As a result this pneumoconiosis he developed multiple small bowel AV malformations. These vascular lesions resulted in chronic and persistent blood loss through his GI tract. He received in excess of 100 units of blood over the last several years because of this persistent bleeding. Unfortunately the bleeding continued to escalate to the point it was no longer controllable and as a result with complication, he expired.
02/18/2004 to 02/26/2007 D-N	Michael Ragosta -	ADMISSION - UNIV OF VIRGINIA - PRIMARY DISCHARGE DIAGNOSIS: CONGESTIVE HEART FAILURE SECONDARY DIAGNOSIS: 1. Severe aortic stenosis status post aortic value repair 2. History of constrictive pericarditis 3. Atrial fibrillation 4. Hypertension 5. Chronic obstructive pulmonary disease 6. sleep apnea; diabetes mellitus; iron deficiency anemia
07/08/2003 to 07/12/2003 D-N	Michael Ragosta -	ADMISSION - UNIV OF VIRGINIA - DISCHARGE DIAGNOSIS: Congestive Heart failure SECONDRY DIAGNOSIS: COPD; obstructive sleep apnea; diabetes mellitus; gout; BPH; hypothyroidism
05/14/2002 to 05/30/2002 D-N	Eric R Powers -	ADMISSION - UNIV OF VIRGINIA - DISCHARGE SUMMARY: PRIMARY DIAGNOSES: Group A Strep toxic shock syndrome; renal failure; gastrointestinal bleed; left lower extremity cellulitis; atrial fibrillation SECONDARY DIAGNOSES: status post St. Jude's aortic valve replacement; chronic obstructive pulmonary disease; diabetes mellitus; hypothyroidism; hypertension
12/11/2000 to 12/24/2000 D-N	Irving L Kron -	ADMISSION - UNIVERSITY OF VIRGINIA - DISCHARGE SUMMARY: PRIMARY DIAGNOSIS: Constrictive pericarditis SECONDARY DIAGNOSES: Include diabetes, hypertension, chronic obstructive pulmonary disease; hypothyroidism; obstructive sleep apnea; paroxysmal atrial fibrillation

11/30/1998 to 12/05/1998 D-N	William D Spotnitz -	ADMISSION - UNIVERITY OF VIRGINIA - On 11/30/98 - Operation: Aortic valve replacement
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Length of Coal Mine Employment

The claimant has proven **38.5** years of coal mine employment.

GUIDE FOR SUBMITTING ADDITIONAL MEDICAL EVIDENCE (SURVIVOR'S CLAIM)

In order to receive Black Lung benefits as a miner's survivor, you must prove three medical "facts":

- The deceased miner had pneumoconiosis (black lung disease);
- The pneumoconiosis was caused at least in part by exposure to coal mine dust; and
- The pneumoconiosis caused, or contributed to, the miner's death.

"Pneumoconiosis" is a chronic lung disease caused by inhaling coal mine dust. X-ray, biopsy and autopsy evidence may show the presence of certain types of pneumoconiosis in the lungs. Pneumoconiosis can also be diagnosed by a physician who finds a lung disease present which is caused by inhaling coal mine dust. Pneumoconiosis "caused" the miner's death if it is the primary reason the miner died. Pneumoconiosis "contributed" to the miner's death if it actually hastened the miner's death.

NOTE: The Black Lung benefits program has limitations on the amount of medical evidence which you can submit to support your claim for benefits. We encourage you to get advice from an attorney or other qualified representative before submitting any additional evidence.

The Black Lung benefits program regulations contain important limitations on the amount of medical evidence parties to a claim may submit. The following guidelines explain the quantity and types of evidence which you and the responsible operator (or the Department of Labor) may submit. You may submit the following types of evidence to prove you are entitled to benefits:

- No more than two chest X-ray interpretations. You may submit two X-ray readings of one film, or one reading each of two different films. **NOTE:** The professional training of the doctor who interprets the X-ray is important. If the doctor is trained as a "B"-reader and/or board-certified radiologist, his or her interpretation may be given more weight than an interpretation by a doctor who is not specially trained;
- No more than one report of each biopsy;
- No more than one report of an autopsy; and
- No more than two medical reports containing a physician's assessment of the cause of the miner's death, including the effect of pneumoconiosis on the miner's death.

You may also submit the following types of evidence: No more than one physician's interpretation of each chest X-ray, autopsy report, or biopsy report submitted by the responsible operator or the Department of Labor;

- No more than one physician's assessment apiece of any other test or procedure submitted by the responsible operator or the Department of Labor;
- No more than one statement from any physician who originally interpreted the chest X-ray or performed a biopsy or autopsy if the responsible operator or the Department of Labor submits rebuttal evidence involving that evidence;
- No more than one additional statement from a physician who prepared a medical report submitted by you if the responsible operator's or Department's rebuttal evidence tends to undermine your physician's conclusions.

You may also submit treatment records from a hospital, clinic, or physician if the deceased miner's treatment involved a lung condition. There is no limit on the number of treatment records which you may submit.

In order to assist you, the "Guide" describes each medical fact which you must prove and the evidence which may prove that fact. When we consider the evidence you submit, we must also consider any other properly submitted evidence as well.

DISEASE: You must prove the deceased miner had pneumoconiosis. You may submit any or all of the following types of evidence:

- A chest X-ray interpreted by a doctor as showing simple or complicated pneumoconiosis.
- A biopsy report of the deceased miner's lung tissue. You may submit one report for each biopsy procedure.

- An autopsy of the deceased miner which includes a review of his or her lungs. You may submit one report on the autopsy.
- A doctor's report which is based on an accurate knowledge of the miner's work and medical history, symptoms, and medical testing. The doctor's report should not be based only on chest X-rays. The doctor must explain why he or she believes the miner's lung condition was caused by working as a coal miner.

Each X-ray, biopsy report, autopsy report, and/or medical report which you submit must also meet our requirements for the proper performance and reporting of these procedures and reports.

CAUSALITY: You must prove the miner's pneumoconiosis was caused at least in part by exposure to coal mine dust.

- If you submit X-ray, biopsy and/or autopsy evidence indicating the miner had pneumoconiosis **AND** the employment evidence indicates the miner worked at least ten years as a coal miner: You are entitled to a presumption that the miner's Black Lung was caused by exposure to coal mine dust. You are not required to submit any medical evidence. The Department of Labor or the responsible operator may submit evidence showing the miner's Black Lung was not caused by exposure to coal mine dust. You may not exceed the limits on the amount of evidence required by the "Guide."

OR

- If you submit X-ray, biopsy and/or autopsy evidence indicating the miner had pneumoconiosis **AND** the employment evidence indicates the miner worked fewer than ten years as a coal miner: You must submit evidence that the miner's exposure to coal mine dust caused his or her Black Lung. An X-ray which shows the miner had Black Lung is not enough to prove that coal mine dust exposure caused the disease. A doctor's opinion that the miner's Black Lung was caused by coal mining may be enough proof if the doctor has an accurate understanding of the miner's employment background. If the miner was exposed to dust, fumes or gasses in any work besides coal mining, the doctor must consider that exposure in his or her opinion. You may not exceed the limits on the amount of evidence required by the "Guide."

OR

- If you submit a medical report from a physician who diagnosed the presence of a lung disease: You must submit evidence that the miner's exposure to coal mine dust caused the lung disease at least in part. A doctor's opinion that the miner's lung disease was caused by coal mining may be enough proof if the doctor has an accurate understanding of the miner's employment background. If the miner was exposed to dust, fumes or gasses in any work besides coal mining, the doctor must consider that exposure in his or her opinion. You may not exceed the limits on the amount of evidence required by the "Guide."

DEATH DUE TO PNEUMOCONIOSIS: You must prove the deceased miner's death was caused by pneumoconiosis or that pneumoconiosis contributed to the miner's death. You may submit any or all of the following types of evidence:

- A chest X-ray interpreted by a doctor as showing complicated pneumoconiosis.
- An autopsy of the deceased miner which includes a review of his or her lungs. The autopsy report must state whether Black Lung was a cause of the miner's death. You may submit one report on the autopsy.
- A doctor's report which is based on an accurate knowledge of the miner's work and medical history, symptoms, medical records and any other evidence relating to the miner's death. The doctor must explain why he or she believes the miner's pneumoconiosis caused, or hastened, the miner's death.

Each X-ray, autopsy report, and/or medical report which you submit must also meet our requirements for the proper performance and reporting of these procedures and reports.

**OPERATOR RESPONSE TO
SCHEDULE FOR SUBMISSION OF
ADDITIONAL EVIDENCE**U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Miner's Name: Jackie L Fitzwater	Claimant's Name: Patricia A Fitzwater	Claim Number: XXX-XX-5934 LW C	OMB No.: 1215-0058 Expires: 12/31/2010
Responsible Operator's Name: Westmoreland Coal Company	Insurer's Name: Self-insured thru Westmoreland Coal Company	Policy No.	

This report is authorized by the Black Lung Benefits Act, as amended (30 U.S.C. 901 et seq.) (20 CFR 725.410). Please check appropriate boxes below. While you are not required to respond, if you fail to do so within 30 days after the District Director's issuance of the schedule for the submission of additional evidence naming you as the responsible operator, you shall be deemed to have accepted liability for this claim (that is, that you will be responsible for payment of any benefits to which the claimant is finally determined to be entitled) and to have waived your right to contest your liability in any further proceeding conducted with respect to this claim. You also will be deemed to have contested the claimant's entitlement to benefits.

A. Liability

The named responsible operator:

- ☐ Agrees it is the responsible operator within the meaning of the Black Lung Benefits Act, liable for any benefits to which the claimant is finally determined to be entitled.
- ☐ Disagrees with its designation as the responsible operator liable for the claim.

If you disagree, the schedule for the submission of additional evidence advises you of the time period within which you may submit evidence relevant to your liability, subject to the limitations imposed by 20 C.F.R. 725.408(b)(2). Absent extraordinary circumstances, **no documentary evidence pertaining to liability shall be admitted in any further proceeding conducted with respect to this claim unless it is submitted to the District Director in compliance with a schedule for the submission of additional evidence.**

B. Claimant's Entitlement

The named responsible operator:

- ☐ Accepts the claimant's entitlement to benefits.
- ☐ Contests the claimant's entitlement to benefits.

If you do not accept the claimant's entitlement to benefits, the schedule for the submission of additional evidence will advise you of the time period within which you may submit evidence relevant to the claimant's entitlement. If you enter no response in this section, you will be deemed to have contested the claimant's entitlement to benefits.

Name and Address of Firm Completing Form	Name of Person Completing Form	
	Title	
	Signature	Date

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, including time for reviewing instructions, searching existing data resources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

☐ **NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

U.S. DEPARTMENT OF LABOR

**Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
Greater Johnstown Tech Park
1 Tech Park Drive, Suite 250
Johnstown, PA 15901-1267**

**December 14, 2009****Phone: (814) 619-7777 or 1-800-347-3754****Telefax: (814) 619-7790**

MINER: Jackie L Fitzwater
CLAIMANT: Patricia A Fitzwater
CLAIM NO.: XXX-XX-5934 LW C

Westmoreland Coal Company
C/O Wells Fargo Disability Mgm
PO Box 3389
Charleston, WV 25333-3389

Dear Sir/Madam:

If you agree with the Proposed Decision and Order awarding benefits, you should have an authorized officer of your organization sign and return to this Office the Agreement to Pay Benefits (Form CM-941). Payment of benefits, in accordance with the rates shown in the Proposed Decision and Order, should begin by the 15th of the month following the month for which the benefits are payable and should include any accrued benefit amount, in accordance with the rates shown in the Proposed Decision and Order.

Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by the District Director. The Proposed Decision and Order becomes effective on the thirtieth (30th) day after issuance if no party timely requests revision or a hearing.

If you wish to contest the Proposed Decision and Order, you must file a written request for revision or request a hearing within 30 days after the date of issuance of the Proposed Decision and Order. You must specify the findings and conclusions with which you disagree. The record will remain open for thirty (30) days unless extended for good cause by the District Director.

If you fail to respond within 30 days, the Proposed Decision and Order will become a final Decision and Order. All rights to further proceedings with respect to the claim shall be considered waived, except as provided in 20 CFR 725.310.

Sincerely,

DAVID M. BALMFORTH
Claims Examiner
1-800-347-3754 ext.7749
1-814-619-7749
Fax: 1-814-619-7790

cc: Patricia A Fitzwater; Westmoreland Coal Company; Self-insured thru Westmoreland Coal Company;
Douglas A. Smoot, Esquire; Lady H Coal Co Inc; Wv CWP Fund

Enclosures: CM-906, Notice of First Payment of Benefits

Director's Exb. No. 30
Consisting of 22 pages.

CM-941, Agreement to Pay Benefits

CM-971d, Benefit Rate Table

Report of Earnings by Bureau of Labor Statistics

**U.S. DEPARTMENT OF LABOR**

**Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
Greater Johnstown Tech Park
1 Tech Park Drive, Suite 250
Johnstown, PA 15901-1267
Phone: (814) 619-7777 or 1-800-347-3754
FAX: (814) 619-7790**

In the Matter of the Claim for Benefits Under the
Black Lung Act

Patricia A Fitzwater
Claimant

v.

Westmoreland Coal Company
Responsible Operator

and

Director, Office of Workers' Compensation
Programs

**PROPOSED DECISION AND ORDER
Award of Benefits-Responsible Operator**

MINER: Jackie L Fitzwater
CLAIM NO.: XXX-XX-5934 LW C

Such development, examination, investigation, and review as is deemed necessary pursuant to the Black Lung Benefits Act having been completed and duly considered, the District Director makes the following:

FINDINGS OF FACT AND CONCLUSION OF LAW

1. That Jackie L Fitzwater, born April 25, 1936, hereinafter referred to as the miner, was employed as a coal miner in the Nation's coal mines for 38.5 years, from August 29, 1956 to July 1, 1994;
2. That notice of disability and written claim for benefits was timely filed on January 16, 2009;
3. That Patricia A Fitzwater, hereinafter referred to as the claimant, is the surviving Living Spouse of Jackie L Fitzwater;
4. That the miner died on September 24, 2008;
5. That as a result of the conditions of his coal mine employment, the miner contracted pneumoconiosis, as that term is defined in the Act and the Regulations;
6. That such disease caused the miner's death within the meaning of the Act and the Regulations;
7. That Westmoreland Coal Company is the coal mine operator designated as responsible for payment of benefits due the claimant;

PROPOSED DECISION AND ORDER AWARDING BENEFITS

Miner: Jackie L Fitzwater

Claim No.: XXX-XX-5934 LW C

Page: 2

8. That the following previously named operators are dismissed as parties to this claim: Lady H Coal Company & WV CWP Fund
9. That the claimant is entitled to receive benefits on his/her own behalf at the following rates:

From	To	No. of Mos.	Monthly Rate	Total
09/2008	12/2008	4	\$599.00	\$2,396.00
01/2009	12/2009	12	\$616.30	\$7,395.60

Total **\$9,791.60**

And continuing at the monthly rate of \$616.30, to be paid on the fifteenth day of the month following the month for which the benefits are due.

Based upon the foregoing Findings of Fact and Conclusions of law, the District Director makes the following:

AWARD

That Westmoreland Coal Company shall pay to the claimant in the amount of \$9,791.60 representing all benefits due up to and including December 2009, and shall thereafter continue to pay benefits to the claimant at the rate of \$616.30 per month, subject to the limitations of the Act.

Within 30 days after the date of issuance of this Proposed Decision and Order, any party may file a written request for revision or request a formal hearing before the Office of Administrative Law Judges. The party must specify the findings and conclusions with which they disagree, and shall serve the written request on the District Director and all other parties.

Signed in the office of the District Director on December 14, 2009.



David Balmforth
Claims Examiner

PROOF OF SERVICE

Claimant: Patricia A Fitzwater

Claim No.: XXX-XX-5934 LW C

CERTIFICATION

I hereby certify that on December 14, 2009, the Decision and Order was filed in the office of the District Director and a certified copy mailed to the parties and their representatives at the addresses listed below.

This Order becomes final and effective thirty (30) days from the date printed on this Proof of Service, unless a party to the claim submits a timely request for revision or hearing before an Administrative Law Judge. If payment is not made within thirty (30) days following the date that this Order becomes final and effective, the responsible operator becomes liable for interest, as provided in the regulations at 20 C.F.R. 725.608. In addition, if payment is not made within ten (10) days after the 15th day of the month following the month for which benefits are payable, a penalty in the amount of 20% of the total compensation award will be due the claimant, in accordance with Section 14(f) of the Longshore and Harbor Workers' Compensation Act (LHWCA), as incorporated by Section 422(a) of the Black Lung Benefits Act, and 20 C.F.R. 725.607.

NOTICE TO CLAIMANT

Once a final award has been issued (an award becomes final if no party files a timely request for revision or appeal) the claimant may apply for enforcement of any interest and/or penalty due from the operator, if the operator failed to make timely payment of compensation, as specified above. The 20 percent additional compensation is payable by the operator even if the effective award is overturned on appeal.

To apply for enforcement of interest and/or penalty, the beneficiary must file suit in the Federal District Court for the district in which the injury occurred (typically, the district in which the miner's last coal mine employment took place).



David Balmforth
Claims Examiner

See the following page for a list of parties served this notice.

CERTIFIED MAIL

Patricia A Fitzwater
PO Box 312
Quinwood, WV 25981

Westmoreland Coal Company
C/O Wells Fargo Disability Mgm
PO Box 3389
Charleston, WV 25333-3389

Self-insured thru Westmoreland Coal Company
C/O Wells Fargo Disability Mgt
PO Box 3389
Charleston, WV 25333-3389

Douglas A. Smoot, Esquire
Jackson & Kelly, PLLC
PO Box 553
Charleston, WV 25322-0553

CERTIFICATE OF FIRST PAYMENT OF BENEFITS

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS

NOTE: Within ten days after the first payment is made, file the original of this certificate with the initiating office. Send a copy to the person receiving benefits. The Black Lung Benefits Act (30 U.S.C. 901 et seq) requires this report. Failure to report can result in a civil penalty of not more than \$500 for each failure or refusal.

1. Name of Disabled or Deceased Coal Miner

Jackie L Fitzwater

2. Miner's Claim Number

XXX-XX-5934 LW C

3. Name and Address of Person to Whom the Check is Made Payable (The Payee)

Patricia A Fitzwater
PO Box 312
Quinwood, WV 25981

4. Name and Address of Coal Mine Operator

Westmoreland Coal Company
C/O Wells Fargo Disability Mgm
PO Box 3389
Charleston, WV 25333-3389

Name and Address of Insurance Carrier

Self-Insured thru Westmoreland Coal Company
C/O Wells Fargo Disability Mgt
PO Box 3389
Charleston, WV 25333-3389

6. Name(s) of Dependent(s) of Disabled or Deceased Coal Miner

N/A

7. a. Last date DOL will issue a benefit check / /
(month/day/year)

b. Responsible Operator to reimburse the Trust Fund (Interim Benefits) for _____ (dates)

\$ _____ (amount)

c. Responsible Operator to begin payment for January 2010 (month/year)

\$ \$616.30 (amount)

d. Responsible Operator to pay lump sum to claimant 09/2008 - 12/2009 (dates)

\$ \$9,791.60 (amount)

e. Responsible Operator to reimburse the Trust Fund for:

medical costs \$ _____ (amount)

interest \$ _____ (amount)

☐ You will be notified of medical costs and interest at a future date.

☐ I hereby certify that I **AGREE** with the information contained in Item 7 of this form and that payments have been initiated as indicated above.

☐ I hereby certify that I **DISAGREE** with the information contained in ITEM 7 of this form but have initiated benefits.

Signature of Person Authorized to Sign for Coal Mine Operator or Insurance Carrier

Date

Print Name and Title

Address

Phone Number

U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
Greater Johnstown Tech Park
1 Tech Park Drive, Suite 250
Johnstown, PA 15901-1267
Phone: (814) 619-7777 or 1-800-347-3754
FAX: (814) 619-7790



In the matter of the claim for benefits
under the Black Lung Benefits Act

AGREEMENT TO PAY BENEFITS

Patricia A Fitzwater

Claim Number: XXX-XX-5934 LW C

Claimant

Westmoreland Coal Company

Coal Mine Operator

Self-insured thru Westmoreland Coal Company

Insurance Carrier

The above-named Coal Mine Operator and/or Insurance Carrier agrees to pay benefits and other costs and expenses pursuant to the Black Lung Benefits Act (30 U.S.C., 931 et seq.), based upon the finding by the Department of Labor of the claimant's eligibility to be paid benefits on his or her own behalf and on behalf of the following dependents: None claimed.

A Proposed Decision and Order issued by a District Director becomes effective on the 30th day after issuance of the Proposed Decision and Order if no party timely requests revision or a hearing. (20 C.F.R. 725.505(a)(2)) At that time benefits become due.

The Responsible Coal Mine Operator agrees to begin to pay benefits by the 15th day of the month following the month that such benefit payments become due and to reimburse the Black Lung Disability Trust Fund for any benefit payments made and any medical development expenses incurred. (20 C.F.R. 725.502(b)(1)) The first payment will include benefits which have accrued from September 1, 2008, with subsequent payment of benefits to be made on the fifteenth (15th) day of each month thereafter.

The Responsible Coal Mine Operator understands and agrees that this document may be the basis for the issuance of an Award of Benefits and Order to Pay benefits in this claim. Notice of First Payment of Benefits (CM-906) should follow this statement.

Signature of Authorized Officer

Date

Name and Title

CM-941
Rev. Nov 2001

TABLE OF MONTHLY BLACK LUNG BENEFIT RATES

	PRIMARY	+1	+2	+3
07/01/73 - 09/30/73	\$ 169.80	\$ 254.70	\$ 297.10	\$ 339.50
10/01/73 - 09/30/74	177.60	266.40	310.80	355.20
10/01/74 - 09/30/75	187.40	281.10	328.00	374.80
10/01/75 - 09/30/76	196.80	295.20	344.40	393.50
10/01/76 - 09/30/77	205.40	308.10	359.50	410.80
10/01/77 - 09/30/78	219.90	329.80	384.80	439.70
10/01/78 - 09/30/79	232.00	348.00	405.90	463.90
10/01/79 - 09/30/80	254.00	381.00	444.50	508.00
10/01/80 - 09/30/81	279.80	419.60	489.60	559.50
10/01/81 - 09/30/82	293.20	439.80	513.10	586.40
10/01/82 - 12/31/83	304.90	457.40	533.60	609.80
01/01/84 - 12/31/84*	317.10	475.60	554.90	634.20
01/01/85 - 12/31/86	328.20	492.30	574.30	656.40
01/01/87 - 12/31/87	338.00	507.00	591.50	676.00
01/01/88 - 12/31/88	344.80	517.20	603.40	689.50
01/01/89 - 12/31/89	358.90	538.40	628.10	717.80
01/01/90 - 12/31/90	371.80	557.70	650.70	743.60
01/01/91 - 12/31/91	387.10	580.60	677.40	774.10
01/01/92 - 12/31/92	403.30	605.00	705.80	806.60
01/01/93 - 12/31/93	418.20	627.30	731.90	836.40
01/01/94 - 12/31/95	427.40	641.10	748.00	854.80
01/01/96 - 12/31/96	435.10	652.70	761.50	870.20
01/01/97 - 12/31/97	445.10	667.70	779.00	890.20
01/01/98 - 12/31/98	455.40	683.10	796.90	910.70
01/01/99 - 02/31/99	469.50	704.30	821.60	939.00
01/01/00 - 12/31/00	487.40	731.00	852.80	974.70
01/01/01 - 12/31/01	500.50	750.80	875.90	1001.00
01/01/02 - 12/31/02	518.50	777.80	907.40	1037.00
01/01/03 - 12/31/03	534.60	801.90	935.50	1069.20
01/01/04 - 12/31/04	549.00	823.50	960.80	1098.00
01/01/05 - 12/31/05	562.80	844.10	984.80	1125.50
01/01/06 - 12/31/06	574.60	861.80	1005.50	1149.10
01/01/07 - 12/31/07	584.40	876.50	1022.60	1168.70
01/01/08 - 12/31/08	599.00	898.40	1048.10	1197.90
01/01/09 -	616.30	924.50	1078.50	1232.60

*These benefit rates include the additional one-half percent increase that was granted retroactive to January 1, 1984. The following rates were in effect prior to the retroactive payments:

01/01/84 - 06/30/84	\$315.60	\$473.30	\$552.20	\$631.10
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**SUMMARY OF MEDICAL AND EMPLOYMENT EVIDENCE
PROPOSED DECISION AND ORDER**

Date Issued: December 14, 2009
Miner's Name: Jackie L Fitzwater
Responsible Operator: Westmoreland Coal
Company

DOL Claim No.: XXX-XX-5934 LW C
Claimant's Name: Patricia A Fitzwater
Insurance Carrier: Self-insured thru
Westmoreland Coal Company

The claimant named above has filed an application under the Black Lung Benefits Act, 30 USC 901 et seq. We have received the medical and employment evidence summarized below. Based on a review of this evidence, we have concluded that Westmoreland Coal Company is the responsible operator liable for the payment of any benefits in this claim. We have also concluded that the claimant would be entitled to benefits. A summary of the medical and employment evidence and an analysis of the evidence are set forth below. Copies of any evidence received following the issuance of the Schedule for the Submission of Additional Evidence are attached to this document.

ENTITLEMENT ANALYSIS:

Based on the analysis of the medical evidence received to date, we have determined the following:

RELATIONSHIP/DEPENDENCY:

The claimant, as an eligible survivor, meets the relationship requirements per 20 CFR 725.212(a) and the dependency requirements per 20 CFR 725.515

PRESENCE OF PNEUMOCONIOSIS (BLACK LUNG DISEASE):

In this widow's claim, the claimant submitted the miner's death certificate, a primary care physician statement and an autopsy report. To assist the claimant, the District Director requested medical evidence from sources identified by the widow and records were received. The death certificate was completed by Dr. M. McShane, a physician licensed to practice medicine in Virginia. Dr. McShane listed the immediate cause of death as renal failure due to or as a consequence of congestive heart failure and infective endocarditis.

The Director developed extensive medical evidence for the record which included treatment records, x-ray reports, test results, and inpatient records for the periods November 30, 1998 to September 24, 2008. These records demonstrated that the miner suffered from multiple ailments that included Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea.

Dr. M. Beatriz Lopes, a physician Board certified in Anatomic Pathology with a subspecialty in Neuropathology performed a chest only autopsy on September 25, 2008. Dr. Lopes final pathologic diagnoses were:

1. Simple Coal Workers' Pneumoconiosis
 - Diffuse Pulmonary Emphysema
 - Anthracotic Nodules
 - Mild Pulmonary Hypertensive Changes
2. Cardiomegaly with Ischemic Cardiomyopathy
 - Batrial Dilatation
 - Right Ventricular Dilatation
 - Left Ventricular Hypertrophy

- Multifocal subacute and remote infarcts(microscopic)
3. Atherosclerosis
 - Aorta: grade VII/VII
 - Coronary arteries: 40% max occlusion with calcification
 4. Status Post Aortic Valve Replacement and Pacer Placement
 - Left chronic fibrotic pleuritis and chronic fibrotic Pericarditis

Dr. Lopes microscopic examination of the lung tissue revealed:

Sections of the lungs demonstrate diffuse emphysematous changes. There are multifocal areas of anthracotic nodules. Mild pulmonary hypertensive vascular changes are present. Bacterial and foreign material are seen in the bronchial tree, without an inflammatory infiltrate. There is pleural anthracosis and pleural thickening in the left lower lobe. There is no evidence of pulmonary emboli.

Dr. Lopes final comments were:

The gross and Histologic findings in this case are consistent with simple coal workers' pneumoconiosis (SWCP). The pathologic features of SCWP include the presence of dust macules and focal emphysema, both of which are required for diagnosis. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules. The Histologic findings were not severe enough to diagnosis complicated coal workers' pneumoconiosis, which requires gross and microscopic zones of fibrosis that most commonly affect the posterior portions of the upper lobes.

In response to the Schedule for the Submission of Additional Evidence, the responsible operator submitted a medical report to support their affirmative case by Dr. E. Osterling Jr., a physician Board Certified in Anatomical and Clinical Pathology and Nuclear Medicine. Dr. Osterling opined:

This gentleman experienced a very mild anthracotic pigmentation within the pleural surface with perivascular and peribronchiolar cuffing with anthracotic pigment. None of these achieve a size that warrants a diagnosis of macular coal workers' pneumoconiosis and clearly there is no evidence of nodular change except for the interstitial lymph node which does not constitute coal workers' pneumoconiosis. In concluding, I would restate with reasonable medical certainty that coal dust was in no way a factor in this gentleman's demise, his lung disease was primarily related to his cardiac disease which is unrelated to coal dust exposure. Unfortunately, without other organs one cannot totally assess the absolute cause of death and I believe if you look at the death certificate you will note that they listed renal failure, congestive heart failure and infective endocarditis. There is no mention of coal workers' pneumoconiosis. I would be largely in agreement with the findings in the autopsy, but do find I have some differing opinions from those set forth in the autopsy protocol.

In evaluating the opinions of the two physicians, I assign greater weight to Dr. Lopes opinion. This is based on Dr. Lopes conclusions that Mr. Fitzwater had Simple Coal Workers Pneumoconiosis because he had both diffuse pulmonary emphysema and multifocal areas of dust macules consistent with simple coal workers' pneumoconiosis(SWCP).

Thus, I find the autopsy evidence in this survivor's claim supports the existence of Coal Workers' Pneumoconiosis and is consistent with the medical evidence of record and the requirements of 20 CFR(a)(2) are met.

20 CFR 719.202(a)(2) – established by biopsy/autopsy

RELATIONSHIP OF BLACK LUNG DISEASE TO COAL MINE EMPLOYMENT

The miner's pneumoconiosis was caused by his coal mine employment based upon the presumption in the regulations, 20 CFR 718.203(b) which states: If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. The miner has established at least ten years of coal mine employment. Reasoned medical opinion does not rule out a connection between the disease and coal mine employment. The presumption has not been rebutted.

20 CFR 718.203(b) - established by presumption

DEATH DUE TO BLACK LUNG DISEASE:

The medical evidence in the record documents an extensive history of diagnosis and treatment for a multitude of diseases which included Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea and Congestive Heart Failure. The Death Certificate lists cause of death as renal failure, congestive heart failure and infective endocarditis. The claimant in support of their claim submitted a statement from Dr. Lynn Smith the claimant's primary care physician for 20 years. Dr. Smith, a physician Board certified in Internal Medicine, opined:

I have been Mr. Fitzwater's primary care attending physician over the past 20 years. Mr. Fitzwater recently died of complications of his underlying lung disease. Autopsy reports document the presence of his underlying pneumoconiosis. As a result of this pneumoconiosis, he developed significant cor pulmonale and developed multiple small bowel AV malformations. These vascular lesions resulted in chronic and persistent blood loss through his GI tract. He received in excess of 100 units of blood over the last several years because of this persistent bleeding. Unfortunately, the bleeding continued to escalate to the point it was no long controllable. As a result of continued bleeding and the complications associated with that, he subsequently expired. It is believed this gentleman died as a direct consequence of his underlying lung disease and the complications that it caused.

In the X-ray evidence, there are two x-ray readings listed. This x-rays were taken when the miner was hospitalized and were not read to detect the presence of pneumoconiosis.

In support of their claim, the responsible submitted a report by Dr. E. Osterling, a physician Board certified in Anatomical and Clinical Pathology and Nuclear Medicine. Dr. Osterling commented:

This gentleman experienced a very mild anthracotic pigmentation within the pleural surface with perivascular and peribronchiolar cuffing with anthracotic pigment. None of these achieves a size that warrant a diagnosis of macular coal workers' pneumoconiosis and clearly there is no evidence of nodular change except for the interstitial lymph node which does not constitute coal workers' pneumoconiosis. Therefore, I would state the following with reasonable medical certainty:

1. There is evidence of minimal anthracotic pigmentation within this gentleman's pleura with a perivascular and peribronchiolar cuffing.
2. This level of dust deposition would not alter pulmonary function.
3. Without alterations in pulmonary function the dust should not have produced respiratory symptomology.

4. Without alterations in structure the dust would not have hastened, contributed to or caused his demise.

In evaluating the two physicians reasoned medical opinions in this claim, I assign greater weight to the statement of Dr. Smith who was the claimant's primary care physician for 20 years. Dr. Smith's conclusions that Mr. Fitzwater's pneumoconiosis resulted in his development of significant cor pulmonale and multiple small bowel AV malformations resulting in persistent bleeding which resulted in his death is well reasoned and supported by the medical evidence in the record. Dr. Osterling's opinion is well-reasoned but his exposure to Mr. Fitzwater was restricted to reviews of the medical records and examination of microscopic slides. Thus, **I assigned greater weight to Dr. Smith's reasoned medical opinion based on his 20 years as Mr. Fitzwater's primary care physician.**

Therefore, I find that the evidence of record is sufficient to establish that pneumoconiosis was a substantially contributing cause because it hastened the miner's death.

20 CFR 718.205(c)(1) – established by competent medical evidence

20 CFR 718.205(c)(5) – death hastened by CWP as a substantially contributing factor.

Based upon the above, the claimant would not be entitled to benefits.

EMPLOYMENT EVIDENCE:

The evidence in file consists of a Social Security Administration Itemized Statement of Earnings, Westmoreland Coal Company employment record dated February 3, 2009, a Mine Worker's Employment History and a UMWA Health and Retirement Funds Certificate of Retirement. The evidence establishes 38.5 years of employment from August 29, 1956 to July 1, 1994. The miner's last day of work is established as July 1, 1994.

LIABILITY ANALYSIS:

Westmoreland Coal Company has been named as the designated responsible operator based upon the following:

1. The designated responsible operator was an operator after 06/30/73 and employed the miner as a miner for not less than one year based upon the evidence.
2. The miner's employment with this operator included at least one working day after 12/31/69 based upon the evidence.
3. There is a rebuttable presumption that coal mine workers were exposed to coal mine dust during all periods of such employment occurring in or around a coal mine or coal preparation facility. The presumption has not been successfully rebutted.
4. This operator or its insurer is financially capable of assuming liability for the payment of benefits in accordance with 20 CFR 725.494(e).
5. This operator is not the last operator that most recently employed the miner but is the last operator that is financially capable of assuming liability for the payment of benefits in accordance with 20 CFR 725.494(3).

The last coal mine operator to employ the miner was Lady H Coal Company from April 1, 1986 to July 1, 1994. Lady H Coal Company was insured by the WV CWP Fund, but the policy was cancelled on March 16, 1994 and there is no evidence that Lady H Coal Company obtained insurance after the policy was cancelled. This means that on the date of last exposure Lady H Coal Company was uninsured. Lady H Coal Company declared bankruptcy and its assets were acquired in 1996 by Green Valley Coal Company, a

subsidary of A. T. Massey. The assets of Lady H Coal Company were purchased free and clear of any liability per the US Bankruptcy Court Southern District West Virginia. Based on this information, Lady H Coal Company cannot be named responsible operator.

The next coal company to employ the miner was Westmoreland Coal Company from August 29, 1956 to March 28, 1986. Westmoreland Coal Company was self insured on the last date of exposure. Westmoreland Coal Company is the responsible operator.

A Notice of Claim was received by the potentially liable operator, Westmoreland Coal Company, on March 9, 2009, as evidenced by the signed return receipt from the post office. The potentially liable operator has failed to timely respond to the Notice of Claim or to timely request an extension of time for response. Therefore, in accordance with 20 CFR 725.408(a)(3), the operator shall not be allowed to contest its liability for the payment of benefits on any of the grounds set forth in the Operator Assertions - 20 CFR 725.408(a)(2).

MEDICAL EVIDENCE

The first letter of the letter codes with the test dates represent the submitting party for the evidence: "D" stands for Director (the Department of Labor), "R" for designated responsible operator, the employer, and "C" for claimant. The second letter of each code indicates if the evidence is Evidence of record or New evidence developed for this claim.)

MINER: Jackie L Fitzwater

CLAIM NO.: XXX-XX-5934 LW C

X-ray Evidence

X-RAY Film Date	Reread Date	Name of Reader	X-RAY Reader Qualifications	Film Quality	X-RAY Interpretation
08/18/2008	08/18/2008 D-E	Sean Martinez	None	1	No significant internal change in moderate right sides pleural effusion with associated atelectasis
08/28/2008	08/28/2008 D-E	Sean Martinez	None	1	No evidence of focal consolidation; unchanged moderate right sides pleural effusion

Pulmonary Function Study (PFS) Evidence

Date	Physician	Age/ Height	FEV1	MVV	FVC	FEV1 FVC	DISABILITY STANDARDS			Valid?
							FEV1	MVV	FVC	

Arterial Blood-gas (ABG) Evidence

Date	Physician	Resting/ Exercise?	PCO2	PO2	PO2 Disability Standards	Altitude	Valid?

Physical Examination/ Other Evidence

Exam Date	Examining Physician/Qualifications	Findings
12/31/2008 C-E	L. Smith Board Certified in Internal Medicine	<p>This letter is in reference to Mr. Jackie Fitzwater. I have been his primary care attending over the past 20 years. Mr. Fitzwater recently died of complications of his underlying lung disease. Autopsy reports, which are included, document the presence of his underlying pneumoconiosis. As a result of this pneumoconiosis, he developed significant cor pulmonale and developed multiple small bowel AV malformations. These vascular lesions resulted in chronic and persistent blood loss through his GI tract. He received in excess of 100 units of blood over the last several years because of this persistent bleeding. Unfortunately the bleeding continued to escalate to the point it was no longer controllable. As a result of continued bleeding and the complications associated with that, he subsequently expired.</p> <p>It is believed this gentleman died as a direct consequence of his</p>

		underlying lung disease and the complications that it caused. The autopsy is subsequent proof of this gentleman to underlying pneumoconiosis.
09/25/2008 D-E	M Beatriz Lopes Board Certified in Anatomic Pathology; Subspecialty in	<p>AUTOPSY REPORT - UNIV. OF VIRGINIA , DEPARTMENT OF PATHOLOGY - FINAL PATHOLOGIC DIAGNOSIS:</p> <p>SIMPLE COAL WORKER'S PNEUMOCONIOSIS -Diffuse pulmonary emphysema -anthracotic nodules -mild pulmonary hypertensive changes</p> <p>CARDIOMEGALY WITH ISCHEMIC CARDIOMYOPATHY -biatrial dilation -right ventricular dilation -left ventricular hypertrophy -multifocal subacute and remote infarcts (microscopic)</p> <p>ATHEROSCLEROSIS -aorta: grade VII/VII -coronary arteries: 40% max occlusion with calcification</p> <p>STATUS POST AORTIC VALVE REPLACEMENT AND PACER PLACEMENT -left chronic fibrotic pleuritis and chronic fibrotic pericarditis</p> <p>The gross and histologic findings in this case are consistent with simple coal worker's pneumoconiosis (SCWP). The pathologic features of SCWP include the presence of dust macules and focal emphysema, both of which are required for diagnosis. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules. The histologic findings were not severe enough to diagnose complicated coal worker's pneumoconiosis which requires gross and microscopic zones of fibrosis that most commonly affect the posterior portions of the upper lobes.</p> <p>Other findings in this case include areas of subacute and chronic myocardial infarction. The decedent's coronary arteries had moderate atherosclerosis, but given his history of repeated GI bleeds, he was prone to bouts of hypotension, which could be responsible for his myocardial ischemia. The decedent also had biatrial and right ventricular dilation, but this is explained by the histologic findings of diffuse emphysema and pulmonary hypertension.</p>
09/24/2008 C-E	K Molly McShane Credentials Unknown	<p>DEATH CERTIFICATE – Renal Failure Congestive heart failure Infective endocarditis</p>
08/24/2008 to 09/24/2008 D-E	Christine M Lin Board Certified in Internal Medicine	<p>ADMISSION - UNIV. OF VIRGINIA - Hospital course per problem below:</p> <ol style="list-style-type: none"> 1. GI Bleed 2. Chronic renal failure with progression to end-state renal disease. 3. Cirrhosis. 4. Urinary tract infection 5. spontaneous bacterial peritonitis 6. Infective endocarditis <p>Patient was receiving anticoagulation for numerous reasons. It became clear during his hospital course that therapeutic anticoagulation increased the patient's bleeding from his intestinal AVMs. No balance could be reached. Although the patient's hematocrit did stabilize, his mental status slowly worsened. The family decided to discontinue dialysis and antibiotics and transition the patient to comfort care with the goal of transferring to an in-patient hospice facility closer to home.</p>

08/01/2008 to 08/24/2008 D-E	Robert S. Gibson Board Certified in Internal Medicine with a subspecialty in Cardiovascular Disease	However, patient passed away on 9/24/08. ADMISSION - UNIV OF VIRGINIA - DISCHARGE DIAGNOSES: 1. Congestive heart failure 2. Mechanical aortic valve infective endocarditis 3. Spontaneous bacterial peritonitis 4. Arteriovenous malformations of the intestines 5. Stroke 6. Atrial fibrillation 7. altered mental status 8. acute kidney injury 9. left subclavian deep vein thrombosis 1
02/18/2004 to 02/26/2007 DE	Michael Ragosta Board Certified in Internal Medicine with subspecialties in Cardiovascular Disease and Interventional Cardiology	ADMISSION - UNIV OF VIRGINIA - PRIMARY DISCHARGE DIAGNOSIS: CONGESTIVE HEART FAILURE SECONDARY DIAGNOSIS: 1. Severe aortic stenosis status post aortic valve repair 2. History of constrictive pericarditis 3. Atrial fibrillation 4. Hypertension 5. Chronic obstructive pulmonary disease 6. sleep apnea; diabetes mellitus; iron deficiency anemia
07/08/2003 to 07/12/2003 D-E	Michael Ragosta Board Certified in Internal Medicine with subspecialties in Cardiovascular Disease and Interventional Cardiology	ADMISSION - UNIV OF VIRGINIA - DISCHARGE DIAGNOSIS: Congestive Heart failure SECONDARY DIAGNOSIS: COPD; obstructive sleep apnea; diabetes mellitus; gout; BPH; hypothyroidism
05/14/2002 to 05/30/2002 D-E	Eric R Powers Board Certified in Internal Medicine with subspecialties in Cardiovascular Disease and Interventional Cardiology	ADMISSION - UNIV OF VIRGINIA - DISCHARGE SUMMARY: PRIMARY DIAGNOSES: Group A Strep toxic shock syndrome; renal failure; gastrointestinal bleed; left lower extremity cellulitis; atrial fibrillation SECONDARY DIAGNOSES: status post St. Jude's aortic valve replacement; chronic obstructive pulmonary disease; diabetes mellitus; hypothyroidism; hypertension
12/11/2000 to 12/24/2000 D-E	Irving L Kron Board Certified in Surgery, Vascular Surgery and Thoracic Surgery	ADMISSION - UNIVERSITY OF VIRGINIA - DISCHARGE SUMMARY: PRIMARY DIAGNOSIS: Constrictive pericarditis SECONDARY DIAGNOSES: Include diabetes, hypertension, chronic obstructive pulmonary disease; hypothyroidism; obstructive sleep apnea; paroxysmal atrial fibrillation
11/30/1998 to 12/05/1998 D-E	William D Spotnitz Board Certified in Surgery	ADMISSION - UNIVERSITY OF VIRGINIA - On 11/30/98 - Operation: Aortic valve replacement
7/28/2009 R-N	Everett F. Oesterling, Jr Board Certified in Anatomical and Clinical Pathology and Nuclear Medicine	Review of Autopsy Slides - Hopefully it has become quite evidence from the previous photos that this gentleman experienced a very mild anthracotic pigmentation within the pleural surface with perivascular and peribronchiolar cuffing with □anthracotic pigment. None of these achieve a size that warrants a diagnosis of macular coal workers' pneumoconiosis and clearly there is no evidence of nodular change

		<p>except for the interstitial lymph node which does not constitute coal workers' pneumoconiosis. Therefore I would state the following with reasonable medical certainty: 1. There is evidence of minimal anthracotic pigmentation within this gentleman's pleura with a perivascular and peribronchiolar cuffing. 2. This level of dust deposition would not alter pulmonary function. 3. Without alterations in pulmonary function the dust should not have produced respiratory symptomology. 4. Without alterations in structure the dust would not have hastened, contributed to or caused his demise.</p> <p>I would restate with reasonable medical certainty that coal dust was in no way a factor in this gentleman's demise, his lung disease was primarily related to his cardiac disease which is unrelated to coal dust exposure. Unfortunately without other organs one cannot totally assess the absolute cause of death and I believe if you look at the death certificate you will note that they listed renal failure, congestive heart failure and infective endocarditis. There is no mention of coal workers' pneumoconiosis. I would be largely in agreement with the findings in the autopsy, but do find have some differing opinions from those set forth in the autopsy protocol.</p>
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Length of Coal Mine Employment

The claimant has proven **38,5** years of coal mine employment.

Table of Coal Mine Industry Average Earnings

ANTHRACITE		BITUMINOUS			
YEAR	YEARLY EARNINGS STANDARD	YEAR	YEARLY EARNINGS STANDARD	YEAR	YEARLY EARNINGS STANDARD
1937	693.75	1937	585 00	1973	5898.75
1938	657.50	1938	525 00	1974	6080.00
1939	705.00	1939	598.75	1975	7405.00
1940	648.75	1940	617.50	1976	8008.75
1941	657.50	1941	750 00	1977	8987.50
1942	705.00	1942	857.50	1978	10038.75
1943	648.75	1943	1057.50	1979	10878.75
1944	733.75	1944	1267.50	1980	10927.50
1945	876.25	1945	1315.00	1981	12100 00
1946	1,060.00	1946	1362.50	1982	12698.75
1947	1,262.50	1947	1606.25	1983	13720 00
1948	1,342.50	1948	1691.25	1984	14800 00
1949	1,447.50	1949	1465 00	1985	15250 00
1950	1,553.75	1950	1633.75	1986	15390 00
1951	1,692.50	1951	1915 00	1987	15750 00
1952	1,750.00	1952	1880 00	1988	15940 00
1953	1,695.00	1953	2097.50	1989	16250 00
1954	1,775.00	1954	2022.50	1990	16710 00
1955	1,935.00	1955	2275.00	1991	17080 00
1956	2,083.75	1956	2472.50	1992	17200 00
1957	2,172.50	1957	2581.25	1993	17260 00
1958	2,130.00	1958	2415 00	1994	17760 00
1959	2,183.75	1959	2661.25	1995	18440 00
1960	2,266.35	1960	2687.50	1996	18740.00
	**	1961	2645.00	1997	19010.00
	**	1962	2717.50	1998	19160.00
	**	1963	2835 00	1999	19340.00
	**	1964	3031.25	2000	19090.00
	**	1965	3222.50	2001	19040.00
	**	1966	3438.50	2002	19640.00
	**	1967	3662.50	2003	19900.00
	**	1968	3801.25	2004	21570.00
	**	1969	4261.25	2005	22060.00
		1970	4777.50	2006	22080.00
		1971	5008.75	2007	21960.00
		1972	5576.25	2008	23270.00

* Figures for 1937-1970 were published by the Bureau of Census. Those for 1971 to present were published by the Bureau of Labor Statistics. All figures are based on annual industry wage survey. After 1990, the Bureau of Labor Statistics stopped keeping records on an annual basis. Standards from that year on are based on multiplying the average hourly rate by 1000 hours. A "year" as defined here is 125 working days.

** After 1960, average wage standards are the same for anthracite and bituminous mines.



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(304) 284-4151

March 21, 2012

Honorable Lystra A. Harris
Administrative Law Judge
Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

Re: Federal Black Lung Claim
Patricia Fitzwater, widow of Jackie Fitzwater v.
Westmoreland Coal Company
OWCP No.: XXX-XX-5934 LW C
Case No.: 2010-BLA-5364
Wells Fargo No. 09-0006
JK Ref. No.: 2809/340

**WESTMORELAND COAL COMPANY'S OBJECTION TO CLAIMANT'S
EXHIBIT AND REQUEST FOR PRE-HEARING EVIDENTIARY RULING**

Dear Judge Harris:

The above-styled federal black lung claim is currently set for hearing on April 17, 2012, in Beckley, West Virginia. On February 15, 2012, Westmoreland Coal Company ("Westmoreland") noticed the deposition of Dr. Kirk Hippensteel for March 30, 2012. On February 15, 2012, Westmoreland also noticed the deposition of Dr. David Rosenberg for April 9, 2012. On February 22, 2012, Westmoreland received the treatment records of Dr. Lynn Smith, consisting of 1,040 pages, identified by Claimant as Claimant's Exhibit 1.

Pursuant to 20 C.F.R. § 725.455(b), Westmoreland objects to Claimant's Exhibit 1. Westmoreland objects to the records after page 402 of Claimant's Exhibit 1 as irrelevant to the adjudication of eligibility for benefits in this case because they are unrelated to a respiratory or pulmonary disease. See 20 C.F.R. §§ 725.410(b) and 414(a)(4). The records contained in those pages consist of lab reports that are unrelated to any respiratory or pulmonary disease. Many of the lab reports relate mostly to Dr. Smith's monitoring Mr. Fitzwater's cholesterol levels, blood sugar levels, and his

Honorable Lystra A. Harris
March 21, 2012
Page 2

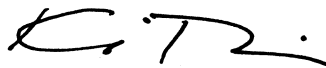
reaction to various doses of anti-coagulation drugs he took after his heart valve replacement.

Claimant has failed to show how these 638 pages of lab reports are related to her husband's respiratory or pulmonary disease. Claimant has generally stated that the lab reports relate to Mr. Fitzwater's overall health and physical condition. See attached Letter from Claimant's Counsel dated February 24, 2012. The applicable regulations mandate medical treatment records must be relevant and relate to respiratory or pulmonary disease to be admissible. See § 725.414. Therefore, as these records do not relate to Mr. Fitzwater's respiratory or pulmonary condition and are not relevant to the issues (pneumoconiosis, pneumoconiosis causation, pulmonary disability, and causation of pulmonary disability) before this Court for adjudication,¹ the 600 some pages of treatment records should not be admitted into the record.

If Westmoreland provides these records to its expert witnesses in preparation for their depositions, it risks the possibility of its expert witnesses' opinions being tainted and accorded less credit or possibly excluded due to their exposure to non-admissible evidence. See Keener v. Peerless Eagle Coal Co., 23 BLR 1-229, 1-242 n. 15 (2007). Conversely, if Westmoreland provides the 600 plus pages of the records to its experts, will incur excessive and unnecessary costs if it must have its expert witnesses review over 600 pages of irrelevant records. One of the purposes of the evidence limiting rules of § 725.414 was to reduce the costs of litigating these claims.

Westmoreland requests that an evidentiary ruling on the admissibility of these records be made prior to the scheduled depositions of Drs. Hippensteel and Rosenberg. In the alternative, if a ruling cannot be made prior to these depositions, Westmoreland requests permission to cancel these depositions and reschedule them post-hearing. See 20 C.F.R. § 725.458.

Sincerely,



Kevin T. Gillen

¹ Even if these records are somehow relevant to the issues before this Court for adjudication, they should be excluded as their probative value is substantially outweighed by considerations of undue delay, waste of time, and needless presentation of cumulative evidence. See 29 C.F.R. § 18.403, see also §18.1101 (noting that the Rules of Evidence at 29 C.F.R. §§ 18.101 - § 18.1008 do not apply in black lung cases "other than with respect to §§ 18.403")

Honorable Lystra A. Harris

March 21, 2012

Page 3

Enclosure

cc: Timothy C. MacDonnell, *by facsimile*
Douglas N. White
Wells Fargo Disability Management



BLACK LUNG LEGAL CLINIC
Timothy C. MacDonnell
Director and Associate Clinical Professor
 540/458-8562
 540/458-8135 *facsimile*

WASHINGTON AND LEE
UNIVERSITY

SCHOOL OF LAW

February 24, 2012

Via UPS Ground and Facsimile

Kevin T. Gillen, Esquire
Jackson Kelly PLLC
150 Clay St, Suite 500
Morgantown, WV 26501

22. PERSONALITY

Re: Patricia A. Fitzwater v. Westmoreland Coal Company and Director, OWCP
OWCP No. XXX-XX-5934; Case No. 2010-BLA-5363

Dear Mr. Gillen:

In the Notice of Hearing, Judge Harris directed that any party submitting records exceeding 25 pages in length should attach a cover page explaining the relevance of the records and provide this summary at the hearing. *See* Notice of Hearing at 2. Claimant will provide the cover page at that time. Claimant understands that you may object to the inclusion of these lab reports.

However, as a brief overview, these lab reports relate to Claimant's overall health and physical condition, and Claimant's cause of death. Claimant contends that his underlying respiratory disease caused his death. These lab reports are relevant to establish this causation.

Thank you for your attention to this matter. If you have any questions, please contact me.

Sincerely,

W. A. D.

Timothy C. MacDonnell
Counsel for Claimant

16-11-20

Chaz Daniel Klaes
Student Caseworker

cc: The Honorable Lystra A. Harris
Mrs. Patricia Fitzwater
Douglas N. White, Esquire
Steven D. Breeskin, Chief



BLACK LUNG LEGAL CLINIC
Timothy C. MacDonnell
Director and Associate Clinical Professor
540/458-8562
540/458-8135 *facsimile*

WASHINGTON AND LEE
UNIVERSITY
SCHOOL OF LAW

March 26, 2012

Via UPS

The Honorable Lystra A. Harris
Office of Administrative Law Judges
U.S. Department of Labor
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

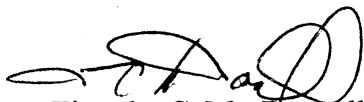
Re: Patricia A. Fitzwater v. Westmoreland Coal Company and Director, OWCP
OWCP No. XXX-XX-5934; Case No. 2010-BLA-5363

Dear Judge Harris:

Please find enclosed Claimant's Response to Employer's Objection to Claimant's Exhibit.
Copies have been sent this day to all parties of record.

Thank you for your attention to this matter.

Sincerely,



Timothy C. MacDonnell
Counsel for Claimant



Chaz Daniel Klaes
Student Caseworker

Enclosure

cc: Kathy L. Snyder, Esquire
Douglas N. White, Esquire
Steve Breeskin, Chief
Mrs. Patricia Fitzwater

UNITED STATES DEPARTMENT OF LABOR
Office of Administrative Law Judges
Cherry Hill, NJ

PATRICIA A. FITZWATER,

Claimant,

v.

WESTMORELAND COAL COMPANY,

Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

Case No. 2010-BLA-5364
OWCP No. XXX-XX-5934

CLAIMANT'S RESPONSE TO EMPLOYER'S OBJECTION O CLAIMANT'S EXHIBIT

Claimant, Patricia A. Fitzwater, moves this Court to overrule the Employer's objection to Claimant's Exhibit. Claimant respectfully shows as follows:

A. Factual Assertions

- a. The above-styled federal black lung claim is currently set for hearing on April 17, 2012.
- b. On February, 15, 2012, the Employer noticed the depositions of Drs. Kirk Hippensteel and David Rosenberg.

- c. On February, 22, 2012, the Employer received the treatment records of Dr. Lynn N. Smith, Claimant's treating physician of twenty-five years, identified as Claimant's Exhibit 1. *See* Employer's Objection at 1.
- d. Dr. Hippensteel's deposition is set for March 30, 2012.
- e. Dr. Rosenberg's deposition is set for April 9, 2012.
- f. In the Notice of Hearing, this Court directed that any party submitting records exceeding 25 pages in length should attach a cover page explaining the relevance of the records and provide this summary at the hearing. *See* Notice of Hearing at 2.
- g. On February 24, 2012, Claimant explained the relevance of these reports to the Employer. *See* attached Letter dated February 24 2012.
- h. Claimant explained that "these lab reports relate to Claimant's overall health and physical condition, and Claimant's cause of death. Claimant contends that his underlying respiratory disease caused his death. These lab reports are relevant to establish this causation." *See Id.*

B. Argument

- a. These reports will not affect the weight of any expert's opinion.

One of the arguments raised by Employer is that should its experts consider the challenged medical records, and the records are excluded, its experts' opinions will be tainted by the inadmissible evidence and thus entitled to less weight. This argument is in error. Even if this Court were to determine that these reports were irrelevant, it would have no affect on the credibility of an expert who considered the records. The Employer, relying on *Keener v. Peerless Eagle Coal Co.*, wrongly contends that if these reports are excluded as irrelevant, then the credibility of its experts could be reduced. 23 BLR 1-229, 1-242 n. 15 (2007). However, *Keener*

did not deal with evidence that was excluded as irrelevant. In *Keener*, the evidence considered by the experts in that case was in excess of the evidentiary limits. Thus, the ALJ had to consider the impact the reports had on the experts and adjust the weight to be given to the experts accordingly. The Employer has only objected on the basis that these lab reports are irrelevant. *See* Employer's Objection at 1. If this Court determines that these reports are irrelevant, then the reports do not relate to any material fact at issue for adjudication in this claim. Thus, the reports would have no effect on the weight given to an expert's opinion because they would not relate to the expert's conclusions.¹

b. The lab reports are relevant to establish causation.

In compliance with this Court's order, Claimant has already explained the relevance of these reports to Employer. *See* attached Letter dated February 24, 2012. These records are relevant to establishing causation in Claimant's case. The records demonstrate that Mr. Fitzwater was continuously on therapeutic anti-coagulation medicine, namely Coumadin, for ten years. These reports show that he remained in the proper range for the medication and had no apparent problem maintaining the appropriate levels. The relevance of Mr. Fitzwater's Coumadin levels became evident during the Employer's cross-examination of Dr. Smith. Mr. Mattingly, counsel for the Employer, asked Dr. Smith about Mr. Fitzwater's Coumadin treatment, and whether there had been any difficulty in maintaining proper levels of Coumadin.

These reports are also relevant because they address and rebut the Employer's claims. The Employer contends that Claimant's death was unrelated to his lung disease. *See* Reports of Dr. Hippensteel dated May 24, 2010, and Dr. Rosenberg dated April 14, 2010. Specifically, the Employer contends that Mr. Fitzwater's death was related to other diseases that required

¹ *See* Federal Rule of Evidence 401—"That rule defines relevance as "having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."

medication. See *Id.* These medical records rebut the Employer's claim because they establish normal blood levels and compliance with other medications.

- c. The probative value of these reports is not substantially outweighed by undue delay, waste of time, and needless presentation of cumulative evidence.

The Employer wrongly contends that these reports are outweighed by the possibility of undue delay, waste of time and needless presentation of evidence. See Employer's Objection at 2 n. 1. However, the Employer provides no basis for this argument and only incorporates it in a footnote. Thus, this argument must be dismissed.

Alternatively, even if this Court entertains such argument, the Employer must demonstrate the substantial prejudice of these reports. Employer can make no such showing because these reports are relevant to proving an essential element of the claim. Thus, the Employer's argument fails.

- d. The Employer will not incur excessive costs.

The Employer contends that it will incur excessive and unnecessary costs if these records are admissible. This argument lacks merit. Although the Employer's experts would need to review these reports, the time it should take their experts to review this material is no longer than it took Claimant's experts.

C. Claimant Objects to Post-Hearing Depositions.

The Employer indicates that if no evidentiary ruling can be made, then it will postpone its scheduled depositions and seek post-hearing depositions. See Employer's Objection at 1. Claimant objects to the Employer's request. The Employer received these reports on February 22, 2012. See Employer's Objection at 1. Claimant has complied with this Court's order, and has already provided the Employer with an explanation of the relevance of these reports. See attached letter dated February 24, 2012. The Employer concedes that it scheduled the depositions of its

experts on February 15, 2012. See Employer's Objection at 1. The Employer could have objected immediately after receiving Claimant's explanation. Further, the Employer has had ample time to review and object to these reports and ample time to have their experts review the reports. Thus, the Employer should not be allowed post-hearing depositions because of its own delay.

D. Conclusion

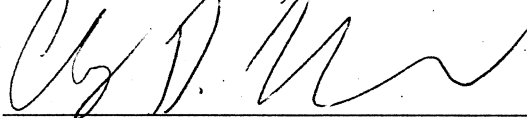
This Court should overrule the Employer's objection. These lab reports are relevant to a material element of the claim. These reports probative value is not outweighed by the danger of delay, waste, or needless presentation. Claimant's submission of these reports will not cause the Employer any excess and unnecessary costs.

WHEREFORE, Claimant, Patricia A. Fitzwater, moves this Court to OVERRULE the Employer's Objection to Claimant's Exhibit and to DENY the Employer's Motion for Post-Hearing depositions.

Respectfully submitted,



Timothy C. MacDonnell
Counsel for Claimant, Patricia A. Fitzwater



Chaz Daniel Klaes
Student Caseworker

Black Lung Clinic, Room 106
Washington and Lee University
School of Law, Lewis Hall
Lexington, VA 24450
540/458-8562 / 540/458-8135

CERTIFICATE OF SERVICE

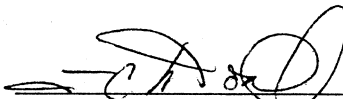
I hereby certify on this day, March 26, 2012, a copy of the foregoing Claimant's Response to Employer's Objection to Claimant's Exhibit was sent to the following parties of record:

Kathy L. Snyder, Esquire
Jackson Kelly PLLC
500 Clay St., Suite 500
Morgantown, WV 26501

Patricia Fitzwater
P.O. Box 312
Quinwood, NC 25524

Douglas N. White, Esquire
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Arlington, VA 22209

Steven D. Breeskin, Chief
U.S. DOL/DCMWC
Room C-3511, FPB
200 Constitution Avenue, N.W.
Washington, D.C. 20210



Timothy C. MacDonnell
Counsel for Claimant

**U. S. DEPARTMENT OF LABOR
OFFICE OF ADMINISTRATIVE LAW JUDGES**

**Patricia A. Fitzwater, Surviving Spouse
of Jackie L. Fitzwater,**

Claimant,

v.

CASE No. 2010-BLA-05364

WESTMORELAND COAL COMPANY,

Employer,

and

**DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS.**

CLOSING ARGUMENT ON BEHALF OF EMPLOYER

The case before this Court was filed by Patricia A. Fitzwater, surviving spouse of Jackie L. Fitzwater (collectively “the claimant”), a miner who died in 2008 as a result of a series of significant medical problems, including a congenital abnormality of his aortic valve, end stage congestive heart failure, and end stage renal failure. The record reflects that he did not have complicated pneumoconiosis prior to his death, he was not totally disabled from simple pneumoconiosis prior to his death, and pneumoconiosis did not cause or substantially contribute to his death.

The claim is governed by the regulations as amended in 2001 found at 20 C.F.R. Part 718 and Part 725. The claim is further governed by 20 C.F.R. § 718.205 which provides that federal black lung benefits are to be paid to eligible survivors of a deceased miner only if

the death was due to pneumoconiosis, and by Section 1556(a) of the Patient Protection and Affordable Care Act ("ACA").

ARGUMENT

I. Westmoreland Coal Company Was Not the Last Employer to Employ the Claimant And Is Not the Proper Responsible Operator in This Claim

The miner's last employer was not Westmoreland Coal Company but The Lady H Coal Co. Mr. Fitzwater worked for Westmoreland Coal Company ("Westmoreland") in various positions from 1956 to 1986, and then he went to work for The Lady H Coal Co. ("Lady H"), where he worked until 1994 when he retired. When this current claim was filed on January 18, 2009, a Certificate of Insurance from the UMWA Health and Retirement Funds was filed which confirmed the claimant's last date of employment with Lady H was July 1, 1994, when he retired. A Request for Identification of Responsible Operator was sent to Westmoreland on February 8, 2010, stating the Lady H policy of insurance was cancelled on March 16, 1994. Lady H declared bankruptcy and the company's assets were acquired by a subsidiary of A. T. Massey, free and clear of any liability per the U.S. Bankruptcy Court, Southern District, West Virginia. Westmoreland was notified of the claim and filed a Controversion on February 17, 2009, challenging being designated as responsible operator.

By response to the Schedule for the Submission of Additional Evidence dated July 15, 2009, Westmoreland's representative noted its Controversion previously filed and confirmed that the Claims Examiner would review the responsible operator issue. Westmoreland's Response to Scheduling Order dated July 24, 2009, again disagreed with the

designation as responsible operator. By Proposed Decision and Order issued by the District Director on December 14, 2009, proposed an award of benefits and Westmoreland was again named as the responsible operator. Liability was once again contested by Westmoreland on December 23, 2009, with no response. Westmoreland was subsequently named as the responsible operator and contested that designation, as well as the Initial Determination issued in this claim on January 7, 2010.

The Department of Labor has failed to reveal the details of the bankruptcy and their involvement in the bankruptcy as creditor. Such information is crucial because in bankruptcy proceedings trust funds can be set up to cover future black lung liability. If any such fund was set up but was insufficiently funded per the agreement of the U.S. Department of Labor, and liability not covered by the fund should fall on the Black Lung Disability Trust Fund. If the Department of Labor failed to participate in the bankruptcy proceedings and assert a claim for black lung liability such that a fund was set up from the assets of Lady H, then liability should fall on the Black Lung Disability Trust Fund. In both scenarios, the due process and property rights of Westmoreland would have been violated and compromised by the Department of Labor failing to assert the proper rights and claims in the bankruptcy proceedings for liability in such claims as the case at bar. The claim should properly be assessed to the Trust Fund.

II. The autopsy evidence, considered the “Gold Standard” for determining the true extent of lung disease, evidence demonstrates that Mr. Fitzwater had very little lung disease from coal mine dust exposure.

The claimant suffered and died from complications caused by a congenital abnormality of his aortic valve, also by his end stage congestive heart failure, end stage renal failure, and other serious medical conditions. None of these conditions were caused, substantially contributed to, nor aggravated by his coal mine dust exposure. In fact, the

claimant's death certificate signed by Dr. Molly McShane of Charlottesville, Virginia,¹ shows his causes of death to be renal failure, congestive heart failure, and infective endocarditis. DX 13, CX 7. Pneumoconiosis was not listed as a cause or contributing factor to the death by the doctors present when Mr. Fitzwater passed away.

The pathology evidence in this case demonstrates, perhaps, why pneumoconiosis was not listed on the death certificate and also shows that the claimant's doctors, Dr. Smith and Dr. Houser, who insisted that pneumoconiosis played a significant role in the health problems and death of Mr. Fitzwater, were misinformed or had assumed incorrectly that Mr. Fitzwater had significant or serious lung disease from coal mine dust exposure.²

¹ The treating physician, Dr. Lynn Smith, was not treating Mr. Fitzwater for his terminal hospitalization because he had been transferred to the University of Virginia. The Death Certificate was signed by the physician who tested and treated and cared for Mr. Fitzwater at the end of his life. That doctor did not list pneumoconiosis as a contributing factor to the death.

² Dr. Smith, who throughout her deposition seemed to insist that Mr. Fitzwater had two lung diseases in the way of pneumoconiosis from coal dust exposure and emphysema from smoking, admitted that she had never independently diagnosed Mr. Fitzwater with pneumoconiosis but had carried the diagnosis forward from the history given to her by the miner. CX 3, pp. 40-41. Such an assumption about significant pneumoconiosis was wrong as seen in the pathology evidence, and was a misassumption that tainted all of her pronouncements about the cause of the underlying lung disease and the etiological impact on other conditions. A similar problem would exist, for instance, if Dr. Smith had assumed a patient had significant pneumoconiosis and used that as a basis for ascribing several other problems to coal mine dust exposure, only to learn on autopsy that the patient did not have pneumoconiosis at all. Here the autopsy did not show there was no lung disease from coal dust exposure, but did show it was too small to have contributed to any impairment.

The autopsy was performed on the chest only even though one of the major problems of Mr. Fitzwater was his intestinal bleeding and renal failure. This was limited by the request of the family. So at the outset, the Court should note that the description of the weeks leading up to the death of the miner showed multiple blood transfusions, dialysis, renal failure, bleeding in the intestines, the claimant did not permit the autopsy prosector to analyze these other organs and provide a complete assessment on Mr. Fitzwater's terminal health problems.

DX 15. In the Final Pathologic Diagnosis, pneumoconiosis is listed, but is specifically noted as simple, not complicated pneumoconiosis, with only "mild pulmonary hypertensive changes."

DX 15, p. 1. There was no significant fluid noted in the lungs, and three other serious diagnoses were included, each with further explanation and subparts: status post aortic valve replacement and pacer placement, atherosclerosis, and cardiomegaly with ischemic cardiomyopathy. DX 15, p. 1-2. Dr. Lopes diagnosed pneumoconiosis pathologically but did not quantify the pneumoconiosis nor the focal emphysema seen. As will be seen below, the other pathologists to look at the autopsy pathology samples did do this. Perhaps the most telling information from Dr. Lopes, is the information she provided which suggests that the other problems of Mr. Fitzwater were what led to his death:

The decedent is a 72 year old male with a past medical history of aortic stenosis secondary to a bicuspid aortic valve s/p aortic valve replacement, sleep apnea, type II diabetes, hypertension, chronic atrial fibrillation (s/p pacer for tachy-brady syndrome), chronic renal failure, coal miner's pneumoconioses [sic] who presented to UVA on 8/2 for recurrent GI bleed secondary to multiple AVMs. The decedent stated that he has had approximately 96 transfusions in the last two years secondary to GI bleeding. *The decedent was transfused and was doing well until the 9th of August, when he became dysarthric and had right sided weakness and was found to have a left thalamic stroke. On the 11th, he became febrile, with blood cultures growing out coag negative staph. On August 14th, he was found to have a thrombus in his left atrial appendage as well as a mass consistent with vegetation on his prosthetic aortic*

valve. Over the next several weeks, the decedent developed spontaneous bacterial peritonitis and worsening renal failure that required dialysis. On the 20th of September, his family made him comfort care and he passed away on the 24th of September.

DX 15, p. 1. [Emphasis added]. This description of the problems and conditions leading to the death of Mr. Fitzwater do not even suggest that lung disease played any role in his demise. On the contrary, it was apparent that he was doing well and then he had a stroke. Then they discovered that he had infection in his heart and a mass of growth there, which developed into bacterial peritonitis and worsening renal failure. His family opted for comfort care and he passed away. It is no accident and no wonder that the death certificate did not list pneumoconiosis or lung disease as a contributing factor to the death of Mr. Fitzwater. It didn't.

The other pathologists provided much more detailed analysis of the lung tissue about the exact impact of coal mine dust exposure on the lungs of Mr. Fitzwater. Dr. Everett F. Oesterling reviewed the lung tissue and rendered a report on dated July 28, 2009. DX 17. He reviewed the claimant's pathology slides prepared at the University of Virginia Health System's Department of Pathology. Dr. Oesterling noted that the claimant's lungs showed no gross evidence of black pigment that would indicate significant coal dust deposition and resulting black lung. DX 17, p. 2. The doctor further noted that the relatively modest quantities of dust seen "suggest a very low level of dust inhalation." DX 17, p. 3. Also present on the slides were multiple cells with a finely stippled cytoplasm, which Dr. Oesterling said was from with the inhalation of tobacco smoke and indicated damage from smoking. DX 17, p. 2. His review did not find any nodules of coalworkers' pneumoconiosis in any of the claimant's lung sections. Inflammatory cells in the lung tissue were not related to coal dust. DX 17, p. 5. Therefore, Dr. Oesterling stated to a reasonable degree of medical certainty that:

coal dust was in no way a factor in this gentleman's demise, his lung disease was primarily related to his cardiac disease which is unrelated to his coal dust exposure.

DX 17, p. 6. His opinion in that regard is not based on speculation, but on direct assessment of the lung tissue from the autopsy.³

Dr. Stephen T. Bush, Board Certified in Pathology, reviewed the claimant's autopsy report prepared in 2008, and also analyzed the tissue slides prepared at the University of Virginia Health Systems ("UVA Hospital"). He rendered a report dated August 27, 2009. EX 1. Dr. Bush noted the claimant's relevant medical history of hypertension, diabetes, and a congenital abnormality of his aortic valve. At his death at age 72, the claimant was admitted to UVA Hospital related to gastrointestinal bleeding caused by his congenital heart valve abnormality and other arteriovenous malformations, where he suffered a stroke. EX 1, p. 2. He closely analyzed the lung tissue from the autopsy and reported that the generalized pulmonary emphysema present as evidenced by enlarged air spaces, was separate from and "has no relationship to the limited dust pigment". EX 1, p. 2. Dr. Bush opined that Mr. Fitzwater was totally disabled prior to his death, noting evidence of a series of heart problems, including a prior myocardial infarction months or years before he died, as well as evidence of another myocardial infarction some weeks before death. He also stated that renal failure and the prosthesis which had been inserted to replace the claimant's aortic valve as a result of his congenital abnormality had become infected. Dr. Bush reported as well a fibrosis measuring .5 cm which was clearly

³ Dr. Smith took some issue with Dr. Oesterling's assignment of the lung problems to heart disease. But the gist of what Dr. Oesterling was saying is that the actual lung tissue from the autopsy does not show sufficient damage from coal mine dust exposure to have caused or contributed to the problems being experienced by Mr. Fitzwater. Regardless of what Dr. Smith thought, the actual lung tissue at autopsy showed what Dr. Oesterling said it showed.

the result of a lung injury and “without relation to coal dust pigment.” EX 1, p. 2. Dr. Bush also reported that Mr. Fitzwater’s slides showed only a minimal degree of simple pneumoconiosis with a limited amount of mineral particles in the claimant’s lungs. He added that “the coal dust disease was too limited in degree and extent to have made any contribution to impairment or disability.” EX 1, p. 2.

Thus, the autopsy reported only that Mr. Fitzwater had simple pneumoconiosis and the pathologists that specifically assessed the extent and damage to the lungs from coal mine dust exposure said that the pneumoconiosis was minimal and that the generalized emphysema present was not associated with the anthracotic pigment or pneumoconiosis present. These pathology assessments provide the Court with a ‘gold standard’ knowledge about the extent of coal mine dust induced lung disease in Mr. Fitzwater. The opinions about whether coal mine dust induced lung disease caused or contributed to the impairment and death of Mr. Fitzwater must be weighed against what the Court knows to be the extent of disease as seen on actual lung tissue analysis. Physicians can speculate and give their best educated assessment of diseases present and the causes of a patient’s health conditions, but pathology evidence shows whether they were right or wrong. The physicians who asserted that coal mine dust exposure played a significant role in impairment and death simply are not supported by the weight of the pathology evidence. The weight of the pathology evidence demonstrates that Mr. Fitzwater in reality had very little lung disease from coal mine dust exposure, but had much lung disease and damage from his long term cigarette smoking of 70 to 80 pack years and his longstanding heart disease.

III. The radiographic evidence supports the finding that there was only a minimal degree of pneumoconiosis which was too minimal to cause or substantially contribute to the miner's impairment, multiple health problems, or death.

As noted earlier, Dr. Smith, the treating physician, never independently diagnosed or tested Mr. Fitzwater for black lung disease but simply carried forward a diagnosis given to her in history by Mr. Fitzwater, and this despite decades of treating him. CX 3, pp. 40-41. Her causation conclusions were therefore predicated not on knowledge about the true extent or even existence of coal mine dust induced lung disease. The weight of the pathology evidence shows her to be wrong in her assumptions. The chest x-ray readings over the years similarly support the finding, as confirmed by pathology, that Mr. Fitzwater had no or very little damage in his lungs from coal mine dust exposure.

The following chart sets forth the radiographic evidence contained in the record:

X-ray Date	X-ray Reading	Physician	Qualifications	Reading	Exhibit
01/22/1981	11/27/1981	Lapp	B	No pneumoconiosis = 0/0 (round opacities); 0/1 (irregular opacities)	EX 2
01/22/1981	04/30/1981	Francke	B/BCR	No x-ray evidence of pneumoconiosis; completely negative x-ray	EX 2
08/18/2008	08/18/2008	Martinez	Not provided	No significant internal change in moderate right sides pleural effusion with associated atelectasis	DX 27
08/28/2008	08/28/2008	Martinez	Not provided	No evidence of focal consolidation; unchanged moderate right sides pleural effusion	DX 27

In addition, there are a large number of additional treatment x-ray readings in the medical records submitted by the claimant. CX 1 (which consists of over 1000 pages). However, of the over thirty x-ray reports which appear in approximately the first 400 pages of CX 1, none diagnose pneumoconiosis nor reference pneumoconiosis. Those x-ray reports do, however,

identify other significant health issues which would have impacted the claimant's health, including an enlarged heart, congestive heart failure, cardiomegaly, and pleural thickening, as examples of a long list of significant health problems from which the claimant was suffering. While the x-ray readings obviously are not as relevant to the question of whether pneumoconiosis exists when there is pathology evidence, they do further support the conclusion that whatever coal mine dust induced lung disease was present, was minimal and only seen upon closer pathology analysis of the lungs.

IV. The medical opinions best supported by the pathology and x-ray evidence confirm that Mr. Fitzwater's death from stroke, infected heart valve, and kidney failure is not related in any way to the minimal coal mine dust induced lung disease confirmed at autopsy.

The applicable regulations provide that eligible survivors of a deceased miner are entitled to federal black lung benefits only if the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205. Absent that ACA presumptions, for death to be due to pneumoconiosis within the meaning of the law, the preponderance of the evidence must establish that death was actually due to pneumoconiosis, that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or that the miner had complicated pneumoconiosis. 20 C.F.R. § 718.205(c). In those cases where the miner's death was due to a medical condition not related to pneumoconiosis, the regulations specifically provide that a surviving spouse is entitled to federal black lung benefits only if the preponderance of the evidence establishes that pneumoconiosis was a "substantially contributing cause of death." 20 C.F.R. § 718.205(c)(4); *Foreman v. Peabody Coal Co.*, 8 BLR 1-371, 1-374 (1985); *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal

aortic aneurysm).⁴ Survivors are not eligible for benefits where the principal cause of death was a medical condition not related to pneumoconiosis, and pneumoconiosis was not a substantially contributing cause of death. 20 C.F.R. §718.205(c)(4) (2000) and (2001).

In this case, if the ACA presumption of death due to pneumoconiosis is invoked, the presumption is rebutted because the best evidence, the evidence supported by the weight of the pathology evidence, demonstrates that the conditions causing the death of Mr. Fitzwater was not caused by coal mine dust induced lung disease. To begin with, the weight of the pathology evidence is that the coal mine dust induced lung disease, both pneumoconiosis and related emphysema, was too minimal to cause or contribute to any health problem or impairment. The evidence relevant to establishing that death was due to pneumoconiosis within the meaning of the Act must be weighed together. Medical opinions cannot be assessed independent of the pathology evidence or the x-ray evidence. In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Administrative Law Judge concluded that the miner did not establish pneumoconiosis through chest x-ray evidence under § 718.202(a)(1), but did find pneumoconiosis established via medical opinion evidence pursuant to § 718.202(a)(4). This approach was rejected by the Fourth Circuit in a decision which held that an Administrative Law Judge must weigh all evidence together. The Circuit Court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which required the same analysis:

⁴ Again, that is similar to the situation here. As Dr. Lopes reported in the autopsy report, Mr. Fitzwater had a stroke in the weeks prior to his death, was then found to have a mass vegetative infection in his artificial heart valve, had a stroke and suffered renal failure, was taken off of dialysis, put on comfort care and passed away. These conditions are not related to coal mine dust induced lung disease.

[W]eighing all of the relevant evidence together makes common sense. Otherwise, the existence of pneumoconiosis could be found even though the evidence as a whole clearly weighed against such a finding.

The Court also rejected the Director's position that the x-rays and medical opinions should be viewed separately because they allegedly measure different types of pneumoconiosis (medical versus legal). The Fourth Circuit found the Director's approach was not a reasonable interpretation of either the Act or the regulations:

[A]lthough we recognize that there is a meaningful distinction between evidence of medical pneumoconiosis and evidence of legal pneumoconiosis, it cannot be said that evidence showing that a miner does not have medical pneumoconiosis is irrelevant to the question of whether the miner has established pneumoconiosis for purposes of a black lung claim. Further, nothing in the text of the regulation supports his position.

Thus, x-rays alone or medical opinions alone cannot be reviewed category by category to determine whether the presumption is overcome or the preponderance of all of the evidence establishes the presence of a coal mine dust induced lung condition or impairment. In this case, when all of the evidence is reviewed together, it is clear that the small amount of coal mine dust induced lung disease Mr. Fitzwater had did not cause, substantially contributed to, or hasten his death from stroke, infected heart and renal (kidney) failure.

The claimant's medical evidence included multiple treatment records, a 1/2 page report, and the transcript of Dr. Lynn Smith's testimony. CX 1, CX 2, CX 3, respectively. The medical treatment records themselves do not provide that coal mine dust induced lung disease caused or contributed to his impairment or death. The testimony of Dr. Smith, the treating physician for years prior to the final weeks of Mr. Fitzwater's life, is fraught with an unsupported assumption that Mr. Fitzwater had significant and serious lung disease from coal mine dust exposure. Her opinion that that coal mine dust induced lung disease contributed to the intestinal

bleeding of Mr. Fitzwater and to his death in a variety of ways is simply misguided and not supported by what the pathologists found after the death of Mr. Fitzwater to be the true nature of his lung disease from coal mine dust exposure.

The records of Dr. Smith outline a history of serious heart problems, including the need to replace the claimant's aortic valve as a result of a congenital condition unrelated to his work. He had a stroke near his death, as had his father, and he also had diabetes, with a history of that same disease in his family. Renal failure was one cause of death, he suffered GI bleeds regularly, and had had cholecystectomy as surgical history.

Dr. Smith's testimony revealed that she based her opinion of causation of impairment and contribution to death on her belief that Mr. Fitzwater had two serious lung diseases present: pneumoconiosis from coal dust exposure and emphysema from smoking.⁵ CX 3, p. 25. Dr. Smith admitted that she had never independently diagnosed pneumoconiosis but carried the diagnosis forward from a history given to her by the miner. CX 3, pp. 40-41. She also admitted that Mr. Fitzwater had a smoking history as high as 80 pack years. *Id.*, p. 15. Her statements are sometimes at odd with each other and with usual understanding about lung disease. For example, at one point she states that the cor pulmonale of Mr. Fitzwater was caused by pneumoconiosis. *Id.*, p. 20. However, later she stated that the cor pulmonale was due to pneumoconiosis, sleep apnea and the valvular heart disease. *Id.*, p. 51. She often said Mr. Fitzwater had COPD. See, e.g., *Id.*, p. 8. But, she also noted that the one pulmonary function test she relied upon did not show any obstruction by FEV1, FVC, or FEV1/FVC ratio, the usual values relied upon and the values used by the Department of Labor regulations, but did show a

⁵ Dr. Smith later said that some of the emphysema could be due to coal dust exposure, but agreed she would defer to the pathologist. CX 3, p. 52.

reduced FEV25/75. *Id.*, pp. 41-42. She even admitted that she herself does not usually use the FEV25/75 to assess impairment and recognized that it made sense that the American Thoracic Society does not recommend using that value. *Id.*, p. 43. While earlier she said that the COPD, assuming it was present, was due to smoking and coal mining, she later said that it was due to smoking, coal mining, the heart disease and the sleep apnea, and even that all of those problems contributed to the underlying lung disease. *Id.*, p. 44. The opinions of Dr. Smith that pneumoconiosis contributed to death have several problems. First, it is clear that all of her opinions about contribution of coal mine dust exposure to death hinges on her belief that the pneumoconiosis was significant and extensive. She, for instance, says the pneumoconiosis contributed to the cor pulmonale, that it contributed to the intestinal bleeding, that it contributed to the COPD, but all of those opinions are based on an unsupported belief, really assumption, that Mr. Fitzwater had pneumoconiosis severe enough to do that. In that regard, the opinion of Dr. Smith has a fatal flaw: she never independently diagnosed pneumoconiosis and the pathology evidence demonstrates that she was wrong in her assumption about the degree or extent of pneumoconiosis. Second, her notion even that Mr. Fitzwater had significant obstruction is based on her use of the FEV25/75 results and she admitted that the usual measures of obstruction (FEV1, FVC, FEV1/FVC ratio) did not show obstruction. Third, she seems to ignore the terminal events which led to the death of Mr. Fitzwater. She concentrates on the intestinal bleeding, which she attributes to the cor pulmonale, but fails to see what Dr. Lopes at the University of Virginia said: that Mr. Fitzwater had a stroke, was found to have a mass of infection around his heart valve, that he went into renal failure, and he died. Fourth, even her assessment of the cor pulmonale, to which she ascribes the intestinal bleeding, was based on a belief that it was caused by smoking induced lung disease, pneumoconiosis, sleep apnea and the valvular heart disease. In

that context, it is difficult to credit her opinion that pneumoconiosis played a significant role in that problem. Moreover, as noted earlier, her notion that pneumoconiosis contributed to cor pulmonale is tainted by her belief that the pneumoconiosis was significant when the weight of the pathology evidence shows that it was not extensive enough to contribute to any impairment. Fifth, it misses the fact that Mr. Fitzwater's main problems were that he had a mass infection around his heart valve, suffered a stroke, had kidney failure, had thrombus (blood clot), was taken off of dialysis and died. As noted, Dr. Lopes reported that Mr. Fitzwater in his last weeks was found to have a mass of vegetative infection in his heart. Dr. Smith even admitted that Fitzwater had mechanic valve infected endocarditis, which was from an infection in his blood stream that was growing in his heart valve, and that such condition put him at risk for stroke and embolic disease. *Id.*, p. Then, as noted above, Dr. Lopes reported that it is exactly what happened to him: he had a stroke and thrombus. In other words, he had exactly the problems from his heart infection that even Dr. Smith said he was at risk of having. Again, in the context of the pathology evidence showing Mr. Fitzwater had too small a degree of lung disease from coal mine dust exposure to contribute to impairment, it is difficult to credit the opinion that in the context of heart infection, stroke and thrombus, none of which were related to coal mine dust exposure, that coal mine dust exposure somehow significantly contributed to or hastened death. In fact, Dr. Smith even admitted that Mr. Fitzwater had pericarditis and that too can cause cor pulmonale. *Id.*, p. 45.⁶ Dr. Smith blamed the intestinal bleeding on the venous pressures Mr. Fitzwater was experiencing because of his cor pulmonale. However, Fitzwater was on anti-coagulation therapy for over a decade because of his congenital heart valve failure and replacement. In other words,

⁶ The Court should also note that claimant's experts disagreed with each other. As noted here, Dr. Smith that that pericarditis causes and caused cor pulmonale, but Dr. Houser said that pericarditis does not cause cor pulmonale. See CX 5, p. 42-43.

Mr. Fitzwater had to have his heart valve replaced and was thereafter ever on anti-coagulation therapy, which causes someone to bleed easily. *Id.*, p. 22. And he began thereafter to experience bleeding in the intestines. In fact, the family stopped his anti-coagulation treatment, which also carries with it a risk of stroke and then he died shortly after having a stroke and thrombus. *Id.*, p. 24. The stroke and embolic disease from which Mr. Fitzwater succumbed was never associated with pneumoconiosis or lung disease. All in all, the opinion of Dr. Smith can be given little weight even though she treated Mr. Fitzwater for a number of years. Her assumption of significant or extensive pneumoconiosis was simply not borne out in the pathology evidence. Plus, her description and admissions of the numerous other significant and end of life conditions (mass infection in the heart, stroke, renal failure) calls further into question her opinions about contribution and causation of impairment and death. Dr. Smith's opinion should be given less weight.

Likewise, the opinions of Dr. William C. Houser on behalf of the claimant should be given less weight. CX 4, CX 4a, CX 5. In his report dated February 15, 2012, he noted the inconsistency in the claimant's smoking history, stating that [t]here are various smoking histories in the file ranging from 30 pack-years to 80 pack-years,⁷ yet still designated smoking as only a "contributing factor" rather than a cause of death. In his deposition taken on March 22, 2012, although Dr. Houser opined the claimant was totally disabled, his sole basis was that the claimant had been on oxygen since approximately 2002, which he attributed entirely to his coal mining experience that ended in 1986. CX 5, p. 10. However, the claimant's medical history suggests other more likely causes for his taking oxygen, including one or a combination of the conditions

⁷ The treating physician, Dr. Smith, confirmed it was 70 to 80 pack years. That is the equivalent of smoking 2 packs of cigarettes per day for 40 years. An intense smoking history.

provided by the doctor in his report: atrial fibrillation, peptic ulcer disease, hypothyroid, cellulitis of the right lower extremity resulting in toxic shock syndrome, diabetes mellitus type 2, obstructive sleep apnea, right pleural effusion, and prior surgeries which included gallbladder and multiple heart surgeries. CX 5, pp. 9-10. With regard to the intestinal bleeding, Dr. Houser never comes right out and attributes the bleeding to coal mine dust induced lung disease. What is amazing is that until asked about it on cross examination, Dr. Houser ignores the obvious medical history of peptic ulcer disease which Mr. Fitzwater had. On cross, Dr. Houser admitted that Mr. Fitzwater had peptic ulcer disease, that peptic ulcer disease causes intestinal bleeding, and has never been associated with coal mine dust exposure. CX 5, p. 54. Plus, as with Dr. Smith, Dr. Houser had to admit that taking anti-coagulant causes or contributes to intestinal bleeding. Mr. Fitzwater began taking anti-coagulants in 1998, a decade before his death. *Id.* And yet, Dr. Houser wants this Court to somehow believe that the intestinal bleeding was due to coal mine dust induced lung disease. In the context of the health problems - the peptic ulcer disease combined with years and years of taking anti-coagulants - it simply is not credible to attribute the intestinal bleeding to problems associated with what the pathologist said was minimal lung disease from coal mine dust exposure. Dr. Houser also admitted that none of the objective tests in this case which he relied upon met the U.S. Department of Labor standards for disability. As with the opinion of Dr. Smith, Dr. Houser chooses to emphasize certain aspects of the medical data to support the claim of Mrs. Fitzpatrick, but inappropriately ignores crucial data about the end of life conditions of Mr. Fitzpatrick including the mass infection in the heart, the stroke, the renal failure, the peptic ulcer disease, the anti-coagulant therapy which increases bleeding, and the removal of dialysis in a patient suffering renal failure. He never explains how those conditions, all of which were clearly life threatening and life ending, would have not ended Mr. Fitzpatrick's life as and

when it happened regardless of the small amount of pneumoconiosis and emphysema associated with coal dust exposure on autopsy. In the context of the medical data on Mr. Fitzpatrick, the causation and contribution opinion of Dr. Houser is not credible.

Dr. Everett F. Oesterling rendered a report on behalf of Westmoreland dated July 28, 2009. DX 17. He reviewed the claimant's pathology slides prepared at the University of Virginia Health System's Department of Pathology prior to rendering his opinion. Dr. Oesterling noted that the claimant's lungs showed no gross evidence of black pigment that would indicate coal dust or black lung, particularly relevant in that the claimant's upper lobes would be the area in which there would be significant amounts of coal dust visible on pathology slides if the claimant had pneumoconiosis. DX 17, p. 2. The doctor further noted that the relatively modest quantities of dust which has been inhaled and that are being removed through the "lymphatic fluids "suggest a very low level of dust inhalation." DX 17, p. 3. Also present on the slides were multiple cells with a finely stippled cytoplasm, which Dr. Oesterling associated with the inhalation of tobacco smoke. DX 17, p. 2. His review did not find any nodules of coalworkers' pneumoconiosis in any of the claimant's lung sections. Inflammatory cells in the lung tissue were not related to coal dust. DX 17, p. 5. Therefore, Dr. Oesterling stated to a reasonable degree of medical certainty that:

coal dust was in no way a factor in this gentleman's demise, his lung disease was primarily related to his cardiac disease which is unrelated to his coal dust exposure.

DX 17, p. 6.

Dr. Stephen T. Bush, Board Certified in Pathology, reviewed the claimant's autopsy report prepared in 2008, and the eight pathology slides prepared at the University of Virginia Health Systems ("UVA Hospital"). He rendered a report dated August 27, 2009. EX

1. Dr. Bush noted the claimant's relevant medical history of hypertension, diabetes, and a congenital abnormality of his aortic valve. At his death at age 72, the claimant was admitted to UVA Hospital related to gastrointestinal bleeding caused by his congenital heart valve abnormality and other arteriovenous malformations, where he suffered a stroke. EX 1, p. 2. He also found generalized pulmonary emphysema evidenced by enlarged air spaces, which the doctor stated "has no relationship to the limited dust pigment" and instead was associated with congestive heart failure. EX 1, p. 2. Dr. Bush opined that Mr. Fitzwater was totally disabled prior to his death, noting evidence of a series of heart problems, including a prior myocardial infarction months or years before he died, as well as evidence of another myocardial infarction some weeks before death. He also stated that renal failure and the prosthesis which had been inserted to replace the claimant's aortic valve as a result of his congenital abnormality had possibly become infected. Dr. Bush reported as well a fibrosis measuring .5 cm which was clearly the result of a lung injury and "without relation to coal dust pigment." EX 1, p. 2.

With respect to the claimant's cause of death, Dr. Bush's review of the claimant's histologic slides showed only a minimal degree of simple pneumoconiosis with a limited amount of mineral particles in the claimant's lungs. Dr. Bush opined:

The minimal degree of simple coal worker's pneumoconiosis did not contribute to the death of Mr. Fitzwater. ...

Coal worker's pneumoconiosis or occupational exposure to coal dust did not contribute to respiratory impairment or disability in Mr. Fitzwater. The coal dust disease was too limited in degree and extent to have made any contribution to impairment or disability.

Coal worker's pneumoconiosis or coal dust exposure played no role in nor hastened the death of Mr. Fitzwater.

EX 1, p. 2. Therefore, Dr. Bush found the claimant's death was unrelated to any respiratory condition.

Westmoreland also introduced the report dated April 14, 2010, of Dr. David M. Rosenberg, Medical Director at the University Hospitals Health System of Cleveland, who holds three board certifications in internal medicine, pulmonary diseases, and occupational medicine.

EX 3. Dr. Rosenberg reviewed extensive medical information related to the claimant, including his autopsy report and information confirming the claimant's death at age 72. He opined that death was related to renal failure which was consequent to congestive heart failure, and he also linked the required valve replacement necessary because of the claimant's congenital malformation that was complicated by pericarditis. Significant was Dr. Rosenberg's noting that "[o]ver a several year period of time he required 100 transfusions to maintain his blood level."

EX 3, p. 9. Dr. Rosenberg opined:

From a radiological perspective, his B readings were negative for the presence of micronodularity. Also, treatment records did not document the presence of this type of abnormality. Furthermore, his spirometry revealed no evidence of restriction, with his FVC being normal. Also, it should be appreciated that he had normal gas exchange in association with exercise, confirming the fact that he did not have chronic interstitial scarring. It should be noted that the latter assessment of measuring arterial blood gas with exercise is one of the best ways to determine whether or not the interstitium of the lung is intact. In the presence of an intact interstitium, gas exchange is normal. As applicable to Mr. Fitzwater his gas exchange was normal. When all the above information is looked at in total, without pathologic confirmation, Mr. Fitzwater was not diagnosable as having clinical CWP. With respect to pathologic findings, Mr. Fitzwater at worst he had a most minimal degree of clinical CWP. ...

EX 3, pp. 9.

With respect to the claimant's other conditions relevant to cause of death, Dr. Rosenberg confirmed the claimant's pulmonary function tests revealed no obstruction or restriction and, therefore, no disability. EX 3, p. 10. Likewise, the doctor noted that the claimant's sleep apnea was inadequately treated, so was placing strain on the right side of the claimant's heart, no doubt contributing to the claimant's pulmonary hypertension. EX 3, p. 10. Dr. Rosenberg also opined that although both coal dust and cigarette smoking can cause emphysema, this claim does not support a diagnosis of legal pneumoconiosis:

with coal dust exposure, the inflammatory response associated with the dust deposited in the lungs causes a disruption of the normal alveolar structures. As such, pathologically, coal dust deposition would be found in close proximity to the emphysema developing in relationship to past coal dust exposure. Specific to Mr. Fitzwater, his emphysema was unassociated with coal dust deposition, and thus, clearly was not caused by past coal dust exposure. His emphysema did not represent the presence of legal CWP. Rather, his emphysema related to his extensive smoking history.

EX 3, p. 11. With respect to the claimant's death, Dr. Rosenberg stated that the claimant died related to complications of his congestive heart failure, which could not be adequately treated due to his renal failure. "This renal failure was not caused or contributed to in any fashion by past coal mine dust exposure." EX 3, p. 11. Nor were the claimant's heart failure or his gastrointestinal bleeding related to arteriovenous malformations attributed to pneumoconiosis. As noted above, the law requires an analysis of the evidence in total and Dr. Rosenberg underscored that burden:

When all the above information is looked at in total, Mr. Fitzwater's death was not caused, hastened or accelerated by past coal mine dust exposure and the presence of CWP. He died primarily from his congestive heart failure and renal failure, both of which were unrelated to past coal mine dust exposure.

EX 3, p. 11.

Dr. Kirk E. Hippensteel reviewed the claimant's medical evidence and rendered an opinion dated May 24, 2010. EX 4. He emphatically stated that any historical diagnosis of pneumoconiosis in the claimant's medical records was unsupported by the objective test results in the medical records. EX 4, p. 11. Dr. Hippensteel noted that minimal simple pneumoconiosis at autopsy, "is the most sensitive and specific test for the presence or absence of pneumoconiosis and trumps the lack of objective evidence of such a disease in life." EX 4, p. 12. However, he found that simple pneumoconiosis seen only at autopsy rarely causes any clinically significant lung impairment or negative cardiac function.

This man does not have objective findings to suggest that he had any effects from his minimal simple coal workers' pneumoconiosis that caused, hastened, or contributed to his death. In other words, it can be stated with a reasonable degree of medical certainty that this man would've died at the same time had he never contracted coal workers' pneumoconiosis from his coal mine dust exposure.

EX 4, p. 12.

Dr. Hippensteel also testified in this case. EX 6. The doctor stated that he was board certified⁸ in internal medicine and pulmonary diseases, as well as being a B-reader. EX 4, p. 4. With respect to his review of the pulmonary function testing introduced by the claimant in 1991, Dr. Hippensteel found the results to rule out pneumoconiosis. He further opined that:

not only is there no evidence of restriction from interstitial fibrosis from his coal mine dust exposure, he has no evidence of emphysema related to either medical or legal pneumoconiosis

EX 6, TR 3/3/2012, p. 21.

Medical opinions are at the core of any decision about the cause of a person's death, and the preponderance of medical opinions in this case do not establish that coal mine dust

⁸ Dr. Hippensteel is also board certified in critical care medicine.


exposure caused to substantially contributed to the claimant's death. The best supported evidence in this case based on the real assessment of the extent of lung damage from coal mine dust exposure pathologically, confirms that the death of Mr. Fitzwater from a mass infection of his mechanical heart valve, stroke, blood clots, and kidney failure resulted in his death when he was taken off of dialysis and put in comfort care to pass away. The limited lung disease from coal mine dust exposure did not cause, contribute or hasten his death from these other life threatening and life ending conditions which were not in any way related to coal mine dust exposure.

CONCLUSION

One role of an Administrative Law Judge is to resolve conflicts in the evidence and assign probative weight. See *Lane v. Union Carbide Corp.*, 105 F.3d 166, 21 BLR 2-34 (4th Cir. 1997); see *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 21 BLR 2-323 (4th Cir. 1998); see also *Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 22 BLR 2-251 (4th Cir. 2000); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Herndon v. CK Coal Corporation*, BRB No. 09-0419 BLA (issued February 22, 2010)(unpublished). The medical evidence supports the employer's position that the best evidence and the greater weight of the evidence does not establish that the claimant is entitled to the ACA presumption since he was not totally disabled due to a respiratory or pulmonary impairment prior to his death and that the abnormalities in blood gases was related to non-lung conditions. Even if invoked, the best supported evidence rebuts the presumption because neither the impairment of Mr. Fitzwater nor his death was related in any way to the small degree of coal mine dust induced lung disease, pneumoconiosis and emphysema, reported by the pathologists

who analyzed his lung tissue on death. For all the foregoing reasons, this claim for federal black lung benefits should be denied.

Respectfully submitted,
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UNITED STATES DEPARTMENT OF LABOR
Office of Administrative Law Judges
Cherry Hill, NJ

PATRICIA F. FITZWATER, Widow
of JACKIE L. FITZWATER,

Claimant,

v.

WESTMORELAND COAL CO.,

Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

CASE No. 2010-BLA-05364

CLAIMANT'S CLOSING ARGUMENT

I. Personal and Employment History

Mr. Jackie L. Fitzwater was born on April 25, 1936. Approximately nineteen years later, he married the Claimant, Patricia A. Fitzwater on November 6, 1955. Over the course of his life, Mr. Fitzwater would work thirty-eight and a half years as a coal miner. He worked as a general laborer, a shuttle car operator, a driller, a shooter, a stationary equipment operator, and a mobile equipment operator. He spent about 10 years of this time actually underground, but he spent the

rest working in the equally dusty tipple of an underground coal mine. Mr. Fitzwater's last job in a coal mine was "dumping cars" in the tipple. Mr. Fitzwater passed away on the 24th of September 2008.

II. Medical History

Mr. Fitzwater's medical history is quite remarkable. In the late 1970's and early 1980's he started going to doctors complaining of chest pain and shortness of breath. The shortness of breath was chronic. Mr. Fitzwater was diagnosed with CWP and COPD. Over the course of the 1980's and early 1990's Mr. Fitzwater underwent a series of x-rays demonstrating emphysematous changes. In 1996 Mr. Fitzwater's heart showed signs of disease on an ECG, and the doctors diagnosed cor pulmonale. In 1998 Mr. Fitzwater underwent a valve replacement surgery to fix a congenital heart defect. Following this surgery Mr. Fitzwater was required to take anti-coagulants in order to prevent a clot from forming. In 2000 Mr. Fitzwater underwent another surgery in order to correct restrictive pericarditis. He began to use oxygen at home. By 2004 he was totally oxygen dependent. Between 1999 and 2008 Mr. Fitzwater's shortness of breath worsened and x-rays showed progressing lung disease. He was hospitalized on numerous occasions. In the last few years of his life, he also developed a serious GI bleed that required repeated transfusions. Mr. Fitzwater's coal dust induced lung disease caused this GI bleed. The bleeding eventually became so severe that he was dying from it. Mr. Fitzwater died on September 24, 2008 from complications directly attributable to his coal dust induced lung disease.

III. Procedural History

After Mr. Fitzwater died, Mrs. Fitzwater filed a claim for survivor's benefits on January 16, 2009. The district director awarded her benefits on December 14, 2009, and Employer appealed that decision. On April 17, 2012, ALJ Harris conducted a hearing.

IV. Summary of the Argument

Mr. Fitzwater developed both clinical and legal pneumoconiosis as a result of the thirty-eight and a half years he spent working as a coal miner. These diseases made Mr. Fitzwater increasingly short of breath and reduced the oxygen level in his blood until he was completely disabled. Mr. Fitzwater ultimately developed cor pulmonale arising from his coal dust induced lung disease. The cor pulmonale, in turn, increased the venous pressure in Mr. Fitzwater's circulatory system to such an extent that it gradually caused his arteriovenous malformations to bleed heavily. In addition to coal dust induced cor pulmonale, Mr. Fitzwater required daily anti-coagulation after having a valve replaced in his heart. A combination of the increased venous pressure and the anti-coagulants caused Mr. Fitzwater's AVMs to bleed so profusely that it was killing him. The doctors could not stop the bleeding without stopping Mr. Fitzwater's therapeutic anti-coagulation. Unfortunately, taking Mr. Fitzwater off his anti-coagulants put him at a substantial risk of developing a clot and dying. Mr. Fitzwater was in an awful catch 22. Based on the advice of his doctors Mr. Fitzwater was taken off of his medication in an effort to halt his bleeding. He developed a clot, and passed away a few days later.

V. Argument

In order for Mrs. Fitzwater to collect Black Lung Benefits she must show that (1) she was a dependent of Mr. Fitzwater when he died, (2) Mr. Fitzwater worked as an underground coal

miner, (3) he had pneumoconiosis when he died, (4) the pneumoconiosis was the result of his coal mine employment, and (5) the pneumoconiosis caused or hastened his death. 20 C.F.R. §§ 718.205(a), 718.205(b)(5), 718.203. Some of these issues are no longer being contested. Employer has conceded that Mrs. Fitzwater was a dependent of Mr. Fitzwater when he died and that Mr. Fitzwater was an underground coal miner. Also, because of Mr. Fitzwater's long term employment as a coal miner, Mrs. Fitzwater is entitled to a presumption that her husband's pneumoconiosis was the result of his coal mine employment, and that it caused or hastened his death. Employer is unable to rebut this presumption. Even if Mrs. Fitzwater was not eligible for the presumption she would still be entitled to benefits. There is sufficient evidence in the record to prove that Mr. Fitzwater had coal worker's pneumoconiosis and that it contributed to his death.

Like most Black Lung cases, the medical evidence in this case is the key to showing why Mrs. Fitzwater is entitled to benefits. However, before addressing the substantive aspects of this evidence, it is necessary to explain why Claimant's medical evidence is more complete, and therefore entitled to much greater weight than that of Employer.

a. The opinions of Dr. Smith and Dr. Houser are entitled to greater weight than the opinions of Dr. Rosenberg and Dr. Hippensteel

1) Dr. Smith's opinion is entitled to greater weight because he was Mr. Fitzwater's treating physician

As Mr. Fitzwater's treating physician, Dr. Smith's opinion regarding Mr. Fitzwater's pulmonary and respiratory condition is entitled to greater weight as compared to the opinions of other doctors. 20 C.F.R. § 718.104(d). In deciding whether a doctor is entitled to the heightened

status of “treating physician” the court should weigh four factors: (1) whether a physician treated a miner for respiratory or pulmonary problems; (2) how long the physician-patient relationship lasted; (3) how often the patient visited the physician during that time; and (4) the extent and types of testing and examinations conducted during the treatment relationship. *Id.*

In the present case Dr. Smith clearly treated Mr. Fitzwater for respiratory problems. Dr. Smith testified extensively in deposition about the medical conditions for which he treated Mr. Fitzwater. Lung disease featured prominently on the list. Smith Deposition at 7-13. Dr. Smith testified that he treated Mr. Fitzwater for “ COPD. . . with associated emphysema and interstitial lung disease, which [he] believe[d] related to [Mr. Fitzwater’s] pneumoconiosis.” *Id.* at 8. In fact, Dr. Smith personally diagnosed Mr. Fitzwater with COPD and coal worker’s pneumoconiosis (CWP). Dr. Smith’s records fully support his testimony. The records are replete with references to Mr. Fitzwater’s coal worker’s pneumoconiosis, chronic obstructive pulmonary disorder (COPD), bronchitis, and other lung based ailments. *See e.g.*, Claimant’s Exhibit 1 at 266, 328, 346, 385. In fact, Dr. Smith treated Mr. Fitzwater for shortness of breath during one of their very first meetings. Smith Deposition at 6. Over the course of Mr. Fitzwater’s treatment Dr. Smith personally ordered PFTs, ABG’s, and no fewer than 10 chest x-rays in order to investigate Mr. Fitzwater’s pulmonary health. Claimant’s Exhibit 1 at 344-47, 352-55, 391-94. He also reviewed the testing that was done at the request of other physicians. Clearly Mr. Fitzwater’s pulmonary problems were a focus of Dr. Smith’s treatment.

In addition to the type of treatment that Dr. Smith gave Mr. Fitzwater, the length of their physician patient relationship supports giving Dr. Smith’s opinion additional weight. 20 C.F.R. § 718.104(d)(2). Dr. Smith testified that he became Mr. Fitzwater’s physician in 1983, and that the relationship did not end until Mr. Fitzwater’s death in 2008. Claimant’s Exhibit 3 at 5. The

treatment records obtained from Dr. Smith further support his assertion. These documents include records stretching from 2008 all the way back to 1978. Dr. Smith was Mr. Fitzwater's physician for at least 25 years. The fourth circuit has previously found that as few as seven years is sufficient to establish a 'treating physician'. *Yogi Min. Co. v. Fife*, 159 Fed. Appx. 441, 444 (4th Cir. 2005) (indicating that ALJ properly credited a miner's treating physician who held that status from 1992 through 1998). Clearly, a history of at least twenty five years is more than sufficient to allow Dr. Smith's opinion to be accorded additional weight.

The frequency of patient visits must also be considered. 20 C.F.R. 718.104(d)(3). Dr. Smith testified that even during periods of relatively good health Mr. Fitzwater would come see him between two and four times per year, and for a number of years leading up to Mr. Fitzwater's death, there were one or two visits a month. Claimant's Exhibit 3 at 6. All told, Dr. Smith stated that his office had eight volumes of charts relating to Mr. Fitzwater's treatment. *Id.* at 7. This kind of frequency establishes that Dr. Smith was spearheading Mr. Fitzwater's care. He was not just a doctor that Mr. Fitzwater went to occasionally. The regularity of Mr. Fitzwater's treatment under Dr. Smith further proves that Dr. Smith's opinion is entitled to additional weight.

The final factor that needs to be considered when assessing whether a doctor's opinion is entitled to additional weight as a 'treating physician' is whether the treatment has been sufficiently extensive; whether sufficient testing and examinations have been performed to provide a doctor with "superior and relevant information concerning the miner's condition." 20 C.F.R. § 718.104(d)(4). Dr. Smith had access to exactly this kind of information. In addition to the x-rays, PFTs, ABGs, and ordinary lab work Dr. Smith personally ordered, *See* Claimant's Exhibit 3 at 7, he also reviewed the findings made by the pulmonary specialist he referred Mr.

Fitzwater to, and the testing and records obtained during Mr. Fitzwater's treatment at other facilities. In total, Dr. Smith had access to over a thousand pages worth of documentation including at least twenty four x-rays, eleven arterial blood gas studies, five pulmonary function tests, and over 600 pages of lab results.

Because of the factors mentioned above Dr. Smith's medical opinion is exactly the type of 'treating physician' opinion that should be accorded greater weight than the opinions of other doctors. He had a trusting, long-standing, and involved relationship with Mr. Fitzwater. Dr. Smith developed a "more in depth knowledge and understanding of [Mr. Fitzwater's] respiratory and pulmonary condition than a physician who examines the miner only once or who reviews others' examination reports." 65 Fed. Reg. at 79,923 (Dec. 20, 2000); *Yogi Min. Co. v. Fife*, 159 Fed. Appx. 441, 444 (4th Cir. 2005).

By contrast Dr. Hippensteel and Dr. Rosenberg never examined Mr. Fitzwater personally. Not even once. Cf. Hippensteel Opinion at 1-28, Rosenberg Opinion at 1. They are doctors who have made their determination after only reviewing "others' examination reports." 65 Fed. Reg. at 79,923 (Dec. 20, 2000); *Yogi Min. Co. v. Fife*, 159 Fed. App. 441, 444 (4th Cir. 2005). Dr. Smith's position as a treating physician is particularly important in this case. Mr. Fitzwater's disease has been slowly progressive, and only Dr. Smith was really in a position to observe the ways that Mr. Fitzwater's diseases progressed. Dr. Smith was there to see Mr. Fitzwater's breathing capability dramatically decline prior to any of his heart conditions beginning. Clearly, Dr. Smith's opinion as to the origin and progression of Mr. Fitzwater's cardiac and pulmonary health should be given far greater weight than the opinion of any other physician.

2) *The opinions of Drs. Hippensteel and Rosenberg are entitled to less weight than either Dr. Smith or Dr. Houser because they failed to examine Claimant's Exhibit 1*

One of the central questions in determining which expert should be given the greatest weight in a black lung case is, which expert has the most well documented and well reasoned opinions. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc). The opinions of Drs. Hippensteel and Rosenberg are not properly documented because they did not review or even know about the existence of Claimant's Exhibit 1. Claimant's Exhibit 1 contains over one thousand pages of treatment records and lab reports from the care that Dr. Smith provided to Mr. Fitzwater. The opinions of Dr. Hippensteel and Dr. Rosenberg should be given even less weight than they would have been given as non-treating physicians. Both the Benefits Review Board and at least one federal circuit have found it appropriate to discredit medical opinions that are supported by more limited documentation than the opposing opinions. *See Sabett v. Director, OWCP [Shores]*, 7 B.L.R. 1-299 (1984); *see also Midland Coal Co. v. Director, OWCP [Shores]*, 358 F.3d 486 (7th Cir. 2004). Among the over one thousand pages of Claimant's Exhibit 1 are sixteen x-ray readings, three pulmonary function tests, five arterial blood gas studies, a large amount of physician commentary and analysis, and over six hundred pages of lab results. Perhaps even more importantly, these records are more or less continuous over the course of Mr. Fitzwater's treatment. *See Claimant's Exhibit 1*. By contrast, the records reviewed by Drs. Rosenberg and Hippensteel contain no information about the years between 1981 and 1998; a gap of 17 years. Employer's Exhibit 7 at 8, Employer's Exhibit 4 at 1-11. Put more bluntly, Drs. Rosenberg and Hippensteel have no idea what happened to Mr. Fitzwater medically for almost two decades of his life. Drs. Rosenberg and Hippensteel could not possibly form a picture of Mr. Fitzwater's condition that is as complete and accurate as the one created by

doctors with an extra thousand pages of medical documentation. Documentation that included at least 400 pages relating directly to Mr. Fitzwater's treatment for lung disease and the resultant cor pulmonale, and records providing information about a seventeen year period that would otherwise be a complete blind spot. Even Dr. Rosenberg recognized the importance of a complete picture during his deposition. He stated that in preparing a medical opinion he decides what is important by "looking at objectively what happened", and then "using [his] clinical experience, [his] clinical expertise, and synthesizing into a coherent picture the medical problems which an individual has." Employer's Exhibit 7 at 7. Dr. Smith and Dr. Houser, who reviewed Claimant's Exhibit 1, could see "objectively what happened" far more clearly than Dr. Hippensteel and Dr. Rosenberg; and as a result they were able to "synthesize" a "coherent picture" far more accurately.

Lacking this much data would make it difficult to properly assess almost any situation, but it is particularly true in this case. As Dr. Smith points out, Mr. Fitzwater's illness was a "progressive process" that got worse gradually over many years. *See* Claimant's Exhibit 3 at 19. Furthermore, there is substantial disagreement between Claimant and Employer's experts as to exactly how Mr. Fitzwater's lung and heart disease interacted with each other and with his arteriovenous malformations. *See*. Given that Dr. Hippensteel and Dr. Rosenberg lacked information about a substantial portion of the progression of Mr. Fitzwater's condition, they were unable to form as complete and accurate a picture of what occurred as could Dr. Houser and especially Dr. Smith. Indeed, Employer's doctors make several statements that are at least called into question, if not outright contradicted, by documents they did not review. For instance, Dr. Hippensteel stated that COPD was put into Mr. Fitzwater's admission reports based on his shortness of breath and his history of smoking and coal mine work, "without any specifics

to say that it was significant clinically.” Employer’s Exhibit 6 at 15. He also states that there was nothing to correlate any “impairment in function” to COPD. Id at 20. Both of these statements are untrue. There are objective x-rays in 1987 and 1994 that show the progression of the COPD that is seen more fully in the 1999 x-rays. Claimant’s Exhibit 1 at 394, 391, 353, 347. Furthermore, in 1991 there was an FEF 25-75 value that was only sixty four percent of predicted. Id at 386. There was no positive response to a bronchodilator, and at the time Dr. Smith noted that the results indicated the presence of an early small airway obstruction. Id. Clearly, Dr. Hippensteel was incorrect about the existence of objective indicators. Additionally, Dr. Rosenberg asserted that diabetes could have been a contributing factor to Mr. Fitzwater’s heart condition. If Dr. Rosenberg had seen the six hundred plus pages of labs from Claimant’s Exhibit 1 he would have known that Mr. Fitzwater’s diabetes was always under complete control. Due to the quantity and importance of the medical records Drs. Hippensteel and Rosenberg did not consider, their opinions are undocumented and should be given little weight.

Because of Dr. Smith’s position as treating physician, his opinion should be given the greatest weight. Dr. Houser’s opinion should be given the next highest value because it is better documented and more well reasoned than the opinions of Drs. Hippensteel and Rosenberg who did not examine Claimant’s Exhibit 1.

b. Mrs. Fitzwater is entitled to a presumption that her husband died as the result of coal dust induced lung disease

Under the regulations if (1) an individual worked for at least 15 years as an underground coal miner or in conditions substantially similar to an underground coal mine, and (2) was totally disabled from a respiratory standpoint at the time of his death, then that individual’s widow is

entitled to a rebuttable presumption that the death was caused by pneumoconiosis resulting from coal mine employment. 20 C.F.R. § 718.305. Mr. Fitzwater was an underground miner for more than 15 years and he was totally disabled from a pulmonary standpoint when he died. Mrs. Fitzwater is therefore entitled to the presumption.

1) Mr. Fitzwater worked as an underground coal miner for more than 15 years

Employer has stipulated that Mr. Fitzwater was an underground coal miner for at least 29 years. *See* Hearing Transcript at 7-8. Therefore, this element is not in contention. Even if that were not the case, there is sufficient evidence in the record to show that Mr. Fitzwater worked as a miner at underground mines for thirty eight and a half years. *See* Director's Exhibit 6; Proposed Decision and Order from District Director dated December 14, 2009.

2) Mr. Fitzwater was totally disabled from a pulmonary standpoint at the time of his death

The medical evidence available in this case clearly shows that Mr. Fitzwater was totally disabled from a respiratory standpoint at the time of his death. Both Dr. Smith, Mr. Fitzwater's treating physician, and Dr. Houser, a board certified pulmonologist, agree that Mr. Fitzwater was totally disabled from a pulmonary standpoint at the time of his death. *See* Claimant's Exhibit 3 at 16, Claimant's Exhibit 5 at 10. The evidence in the record fully supports this conclusion. Mr. Fitzwater started using oxygen in the early 2000's, and by the time of his death he was totally oxygen dependent. Claimant's Exhibit 3 at 15. He was prescribed albuterol, combivent and seravent, three drugs designed to combat the effects of chronic lung diseases including COPD.

Mr. Fitzwater's PFT, ABG, and x-ray results show clear evidence of a progressive lung disease gradually worsening until it ultimately becomes totally disabling. In 1978, Mr. Fitzwater underwent several tests, including ABGs and PFT's, although a number of the elements of these studies showed normal values, Mr. Fitzwater's diffusion capacity was only 70% of what it should have been. Claimant's Exhibit 1 at 396. He showed a "moderately impaired" intrapulmonary oxygen transfer and his O2 level on his ABG dropped during exercise. Id. Further, at that time, Mr. Fitzwater had already been complaining of shortness of breath for seven to eight years and only managed to perform the exercise test with substantial difficulty. Id. The doctor performing the test concluded that Mr. Fitzwater's loss of functional capacity was in the neighborhood of 60%. Id. The very next year Mr. Fitzwater was tested again. This time his PFT showed a "mild obstructive defect" and his ABGs showed a "moderate degree of hypoxemia." Employer's Exhibit 2 at 4, 10. Another PFT was performed in 1982. This time Mr. Fitzwater's FEV1 was 75% of the predicted value and the FEV1/FVC ratio was 76% of predicted. Employer's Exhibit 2 at. Similar values were recorded during a PFT in 1984. Claimant's Exhibit 1 at 400. Finally in 1991, one more PFT was taken, again showing FVC and FEV1 values that had dropped by 10 percent since 1984. Id at 393. This test also showed a reduced FEF 25-75, which is noted as being indicative of small airway disease. Claimant's Exhibit 1 at 386. Finally, in 1999, a pulmonary specialist who had seen Mr. Fitzwater asserted that he was concerned by the "restrictive nature of [Mr. Fitzwater's] pulmonary function studies." Claimant's Exhibit 1 at 380.

Mr. Fitzwater's ABG's tell a similar story. The test done in March of 1999 gave a pO2 of 65 and a pCO2 of 44. Claimant's Exhibit 1 at 380. This test showed some minor hypercapnea. Claimant's Exhibit 3 at 9. More telling is the ABG from January 2001 that was

done on 32 percent O₂, where Mr. Fitzwater had a pO₂ of 54 and a pCO₂ of 49. Claimant's Exhibit 1 at 136. These numbers show much more notable level hypercapnea as well as significant hypoxia despite the fact that Mr. Fitzwater had oxygen supplementation. Claimant's Exhibit 3 at 9. Then in 2002 and 2004 while using additional oxygen, Mr. Fitzwater had pO₂ values of 78 and 71, and pCO₂ values of 40 and 51 respectively. *Id.* These tests are all evidence that Mr. Fitzwater had the hypercapnea and hypoxia that is the result of serious lung disease. *Id.*

There is also substantial x-ray evidence showing the advance of the pulmonary dysfunction that was causing Mr. Fitzwater's impairment. An x-ray taken in 1987 shows the presence of hyperinflation consistent with emphysema. *Id.* at 394. A 1994 x-ray shows an increase in chronic lung markings. *Id.* at 391. An x-ray from January 1998 shows pulmonary fibrosis, and one from a few months later showed scarring and a normal heart size. Claimant's Exhibit 1 at 356-57. Then a series in 1999 and 2001 showed hyperinflation with continuing increases in the scarring associated with CWP and provided a diagnosis of COPD. Claimant's Exhibit 1 at 346-47, 353, 62.

As pointed out by Drs. Houser and Smith, the combination of PFT, ABG, and X-ray are clear evidence of a progressive, severe lung disease. That conclusion is further supported by the first hand observation provided by Ms. Pardue, Mr. Fitzwater's daughter. Ms. Pardue testified that she personally witnessed the gradual decline of her father's respiratory health. Hearing Transcript at 28-34. Ms. Pardue stated that she first noted her father's breathing problems because he had to stop playing with her little sister as much, or as long, because he was so short of breath. *Id.* at 28. She stated that over time he became more and more short of breath. He had to pick and choose the activities that he could do, based on whether there was a way for him to rest in the process. *Id.* at 31. By the late 70's or early 80's Mr. Fitzwater was no longer able to

cut his grass. Id at 31. Finally, by 1996 or 1997, Mr. Fitzwater's shortness of breath became so debilitating that he was no longer able to attend the football games and racing events that he enjoyed. Id at 30. Getting into the stadium or out to the raceway was simply too difficult. Id. The difficulty he had breathing necessitated that he walk too slowly and take too many breaks. Mrs. Pardue's testimony, in combination with the objective medical evidence mentioned above, paints a very clear picture of a man whose lung disease lowered his function bit by bit, until he finally reached the point where he was totally disabled.

Despite the evidence of a pulmonary disability, Dr. Hippensteel and Dr. Rosenberg do not attribute Mr. Fitzwater's total disability to a primary pulmonary disease. Rather, they blame the disability on heart disease. Employer's Exhibit 3 at 10, Employer's Exhibit 4 at 11-12. However, the two doctors' claims are not supported by the medical evidence of record, and are not even in complete agreement regarding exactly how the heart caused Mr. Fitzwater's condition.

In contradiction to the myriad of medical documents that repeatedly diagnose Mr. Fitzwater with COPD and CWP, *see e.g.*, Claimant's Exhibit 1 at, Dr. Rosenberg and Dr. Hippensteel insist that none of Mr. Fitzwater's disability was the result of a primary pulmonary illness. They state that at most Mr. Fitzwater had minimal CWP, and actually rejects the notion that he had COPD at all. Employer's Exhibit 7 at 28. Instead, Dr. Rosenberg believes that all of Mr. Fitzwater's disability can be laid at the feet of Mr. Fitzwater's heart disease, which Dr. Rosenberg further asserts was unrelated to any lung disease. Employer's Exhibit 3 at 10. Dr. Rosenberg believes that the primary cause of Mr. Fitzwater's disability was critical aortic stenosis, and recurrent right-sided heart failure associated with pulmonary hypertension. Employer's Exhibit 3 at 10, Employer's Exhibit 7 at 10. He claims to rule out any respiratory

cause by stating that there are no pulmonary function tests showing that Mr. Fitzwater had an obstruction or restriction on his pulmonary function, and that Mr. Fitzwater's gas exchange did not show change with exercise. Additionally, he states that lacking such tests, there was no evidence upon which Mr. Fitzwater could have been properly diagnosed with COPD, and so Mr. Fitzwater did not properly have any history of lung disease. Employer's Exhibit 7 at 28.

The doctors' stance has a number of flaws. First, it grossly mischaracterizes the record. There *were* PFTs showing a respiratory impairment. The PFTs from February of 1984 and February of 1991, found in Claimant's Exhibit 1 on page 400 and 386 respectively, show significantly reduced spirometry values. The report from 1991 even explicitly states that the values are indicative of early obstructive lung disease, and small airway disease. Furthermore, although the report from the pulmonologist Dr. Durham in 1999 doesn't list specific PFT values, it does express the Doctor's concerns over the "restrictive nature" of the PFT results he had taken. Claimant's Exhibit 1 at 380. Furthermore, the ABG taken on March 26, 1999 showed a pO₂ of 65, a pCO₂ of 44, a pH of 7.46, and an oxygen level drop of six percent with exercise. As Dr. Houser noted, these values are irregular and show a respiratory impairment. The O₂ drop in particular is proof that Mr. Fitzwater had a pulmonary impairment. Claimant's Exhibit 5 at 22-23. Of course, these tests are all found within Claimant's Exhibit 1 which Drs. Rosenberg and Hippensteel never reviewed, so they had no way of knowing that they were making incorrect assessments of the record. Dr. Rosenberg's statement that there was no basis on which to diagnose COPD is also untrue. Dr. Rosenberg states that because Mr. Fitzwater didn't have certain FEV₁ values he couldn't have "class one, gold standard COPD." Employer's Exhibit 7 at 28. Dr. Rosenberg's statement that there was not basis on which to diagnose COPD is incorrect because of the presence of the PFTs, ABGs, and x-rays mentioned above, that all

evidence the presence of COPD. Dr. Rosenberg's opinion contradicts other statements he has made because he acknowledges that emphysema is a type of COPD, and that emphysema can be properly diagnosed by x-ray. See Employer's Exhibit 7 at 30-31. Considering this acknowledgment, the presence of PFT and ABG results showing respiratory impairment, and x-ray evidence of chronic progressive emphysema, the Dr. Rosenberg's assertion is clearly incorrect and poorly reasoned.

The assertion made by Dr. Rosenberg that Mr. Fitzwater's impairment only began after his surgery for aortic stenosis and the heart disease that came in the years after is also flawed. It ignores several important facts. Despite Dr. Rosenberg's assertions to the contrary, there are test results as far back as 1978 showing that Mr. Fitzwater was having significant respiratory trouble. Claimant's Exhibit 1 at 386, 400. Furthermore, Dr. Smith testified that Mr. Fitzwater complained of shortness of breath on his very first visit in 1983, and his records indicate that those complaints began in 1978 at the latest. Id at 396, Claimant's Exhibit 3 at 6. This shortness of breath was not caused by aortic stenosis. As Dr. Rosenberg points out, if Mr. Fitzwater had been short of breath because of his aortic stenosis he would only have had about six months to live. Employer's Exhibit 7 at 36-37. Since Mr. Fitzwater's early impairment cannot be laid at the feet of heart disease, it is only reasonable to connect it instead to the progressive lung disease shown by the x-rays beginning in 1987. Claimant's Exhibit 1 at 394. Dr. Rosenberg's claim regarding Mr. Fitzwater's impairment is also incapable of explaining why Ms. Pardue witnessed her father's shortness of breath begin to cause his slow decline in activity in the 1970's.

Finally, Employer's doctors' opinions clearly ignore the evidence arising from Mr. Fitzwater's autopsy. The autopsy physician, Dr. Lopes, clearly notes the presence of coal worker's pneumoconiosis and *diffuse* pulmonary emphysema. Claimant's Exhibit 8. Yet despite

the fact that this autopsy fully supports the diagnosis of COPD and CWP that had been applied to Mr. Fitzwater since the early eighties, Dr. Rosenberg and Dr. Hippensteel decided that the emphysema and coal worker's pneumoconiosis were too light to have made any clinical difference. The doctors based this decision on the readings of Drs. Bush and Oesterling, who conclude that the emphysema is only "focal" and is not severe. This is despite the fact that Dr. Lopes, who is the head of pathology at UVA, and the only doctor who was able to review the gross findings, diagnosed the emphysema as being "diffuse" and therefore fairly severe. Claimant's Exhibit 5 at 31. Drs. Hippensteel and Rosenberg are either unaware of, or are closing their eyes to, obvious evidence that Mr. Fitzwater had a pulmonary impairment that began before, and ultimately caused his heart problems.

c. Employer is unable to rebut the presumption that Mr. Fitzwater died as the result of his coal mine induced pneumoconiosis

Because Mr. Fitzwater's condition satisfied all of the prongs necessary to provide Mrs. Fitzwater with a rebuttable presumption that her husband's death was caused or hastened by his coal mine induced pneumoconiosis she is entitled to benefits unless Employer can rebut the presumption. The rebuttal can only be accomplished by proving one of two things; that (1) Mr. Fitzwater did not have pneumoconiosis or (2) that respiratory impairment was not the result of his coal mine employment. 30 U.S.C. § 921(c)(4) (2010). Employer will not be able to prove either of these elements.

1) Mr. Fitzwater had clinical pneumoconiosis

Employer will not be able to prove that Mr. Fitzwater did not have clinical pneumoconiosis because almost every expert involved in this case has agreed that he did. Dr. Smith has been diagnosing Mr. Fitzwater with coal worker's pneumoconiosis since 1983. See Claimant's Exhibit 3 at 8. That diagnosis was confirmed by Mr. Fitzwater's autopsy report. Director's Exhibit 15 at 3. The report stated that the Mr. Fitzwater showed the presence of multi-focal areas of dust macules necessary for simple coal worker's pneumoconiosis. Id. Based on these pathologic findings, Mr. Fitzwater's nearly 40 year history as a coal miner, his history of chronic respiratory disease, and the presence of scarring on the lungs Dr. Houser concluded that Mr. Fitzwater had pneumoconiosis. Claimant's Exhibit 4 at 2-4, Claimant's Exhibit 5 at 41. Even Dr. Hippensteel acknowledged that autopsy findings prove conclusively that Mr. Fitzwater had clinical pneumoconiosis. In his review of the autopsy slides, Dr. Bush agrees with Dr. Lopes about the presence of coal worker's pneumoconiosis. Employer's Exhibit 1.

The only doctors who did not explicitly diagnose clinical CWP are Dr. Rosenberg and Dr. Oesterling. Dr. Rosenberg is willing to go so far as to say that there is no *more* than a mild case of simple coal worker's pneumoconiosis. Employer's Exhibit 3 at 9. But Dr. Oesterling stands in contradiction of all the other physician and states there is no CWP, though even he is forced to acknowledge the presence of coal in Mr. Fitzwater's lungs. Director's Exhibit 17 at 5. He simply does not accept that the size of the dust macules is sufficient to diagnose coal worker's pneumoconiosis. Id.

There is a reason that Dr. Oesterling is alone in his belief that Mr. Fitzwater did not have CWP. He is wrong. There was coal in Mr. Fitzwater's lungs, it caused the scarring necessary for a CWP diagnosis, employer's other pathologist diagnosed CWP, and the only doctor who

actually saw the inside of Mr. Fitzwater's lungs diagnosed CWP. Dr. Oesterling is trying to deny the obvious. Mr. Fitzwater had clinical pneumoconiosis.

Because coal macules were seen in Mr. Fitzwater's lung tissue, and almost all of the doctors agree that it constitutes clinical pneumoconiosis, Employer will not be able to prove that Mr. Fitzwater did not have clinical pneumoconiosis.

2) Mr. Fitzwater's respiratory impairment was the result of his coal mine employment

In order for Employer to prove that Mr. Fitzwater's respiratory impairment was not the result of his coal mine employment, Employer must rule out coal dust as a causative agent. 20 C.F.R. § 718.305. Employer cannot accomplish this for a number of reasons.

As pointed out above, the doctors involved in this case almost unanimously agree that Mr. Fitzwater had clinical pneumoconiosis. Therefore, in order for Employer to rule out coal as a causative agent of Mr. Fitzwater's respiratory impairment they have to prove that the clinical pneumoconiosis was having no effect on Mr. Fitzwater's respiratory capability. Given that the coal had formed fibrotic lesions, it is highly unlikely that Mr. Fitzwater's clinical pneumoconiosis was so benign. See Director's Exhibit 15 at 3. It is even less likely given that there are several reports of restrictive lung disease throughout the record. See e.g., Claimant's Exhibit 1 at 380.

Even if Employer were able to prove that Mr. Fitzwater's clinical pneumoconiosis was having no adverse effect on his respiratory capabilities, they would still have to prove that Mr. Fitzwater either did not have or was unaffected by legal pneumoconiosis. Mr. Fitzwater's emphysema is very well documented. The autopsy results in particular describe it as "diffuse", indicating that it was quite extensive and severe. Claimant's Exhibit 3 at 31. Further, this

emphysema was so severe that it was diagnosed in several x-rays. See e.g., Claimant's Exhibit 1 at 394, 344. Mr. Fitzwater's severe shortness of breath, objective evidence of cor pulmonale, poor diffusion capacity, severely abnormal ABG results even when on oxygen, all corroborate the diagnosis of emphysema. Therefore, in order for Employer to rebut the presumption, they must rule out coal as a contributing factor to Mr. Fitzwater's emphysema. Employer cannot do so. Employer's experts offer no medical studies or reasoned explanation as to why Mr. Fitzwater's thirty eight and a half years of coal mining did not significantly contribute to his disabling emphysema. This is in stark contrast to Claimant's experts. Dr. Houser, in particular, provides medical studies and a clear explanation of how and why coal dust contributed to Mr. Fitzwater's emphysema. See Claimant's Exhibit 5 at 31-35.

Part of why Dr. Rosenberg and Hippensteel's opinions are flawed is they place an undue reliance on the pathology reports of Drs. Bush and Oesterling.

Dr. Bush accepts the presence of CWP, and even Dr. Oesterling accepts that the coal deposits in Mr. Fitzwater's lung have caused some lesions. Bush Report at 2-3; Oesterling Report at 5. Further, Dr. Bush diagnosed emphysema, which is caused by coal dust. Despite these conclusions, they claim there is inadequate evidence of dust to cause pulmonary impairment. Director's Exhibit 17 at 5, Employer's Exhibit 1. Not only are these conclusions at odds with the objective medical evidence that demonstrates severe pulmonary impairment, but also they are contradicted by Dr. Lopes' conclusions that Mr. Fitzwater suffered from diffuse pulmonary emphysema, had multifocal areas of dust macules, and suffered from simple coal workers pneumoconiosis. See Director's Exhibit 15, Claimant's Exhibit 5 at 32-33.

Dr. Lopes' opinion is deserving of greater weight. First, Dr. Lopes conducted the gross exam of Mr. Fitzwater's lungs and based on that exam found diffuse emphysema. See Director's Exhibit 15 at 1-3, Claimant's Exhibit 5 at 31. By conducting the gross exam, Dr. Lopes was able to examine much more tissue before reaching her conclusions regarding Mr. Fitzwater's lung disease. *Id.* By comparison, Drs. Oesterling and Bush only had five slides of Mr. Fitzwater's lungs, millimeters thick and less than an inch long. Employer's Exhibit 6 at 37. Furthermore, Dr. Lopes is the head of pathology at the University of Virginia Medical Center, a world renowned medical facility. The only reasonable explanation for Mr. Fitzwater's pulmonary disability is the one offered by Dr. Houser and Dr. Smith. Both cigarettes and coal mine dust contributed to Mr. Fitzwater's emphysema. Claimant's Exhibit 5 at 37-38, Claimant's Exhibit 3 at 8. Therefore, Employer will not be able to rebut this presumption.

d. If Mrs. Fitzwater is not entitled to the presumption, she is still entitled to receive benefits because Mr. Fitzwater satisfies all necessary criteria without the assistance of the presumption

Even if Mrs. Fitzwater is not entitled to the presumption discussed in section b, the medical evidence available in this case is still more than sufficient to prove that Mr. Fitzwater had clinical and legal coal worker's pneumoconiosis and that the disease caused or hastened his death. Sections (c)(1) and (c)(2) have already sufficiently shown that Mr. Fitzwater had pneumoconiosis. Therefore, all that remains to be proven is that Mr. Fitzwater's death was caused or hastened by his coal mine dust induced lung disease.

1) Mr. Fitzwater's death was caused/hastened by his coal mine dust induced lung disease

The sections above have provided sufficient evidence to prove that Mr. Fitzwater had a respiratory impairment that was the result of his coal mine employment. That means the only element remaining to be proven in order for Mrs. Fitzwater to be eligible for benefits is that her husband's death was caused or hastened by his coal mine dust induced lung disease. In this case the course of damage that ultimately resulted in Mr. Fitzwater's death is involved, but there can be no question that his coal mine dust induced lung disease was ultimately responsible. As pointed out above, Mr. Fitzwater's breathing impairment caused him to have the type of right sided heart failure known as cor pulmonale. See e.g. Claimant's Exhibit 3 at 19. This combination of the lung disease and the resulting cor pulmonale created a substantial increase in venous pressure (pulmonary hypertension), which in turn caused the arteriovenous malformations (AVMs) in Mr. Fitzwater's intestines to bleed. Id at 17-18, Claimant's Exhibit 5 at 47-48. As a result of the anti-coagulant that Mr. Fitzwater was forced to take due to his artificial heart valve, the bleeding was even worse than it would have been otherwise. It should be noted however, that without the pulmonary hypertension and cor pulmonale, the anti-coagulant could not independently cause a bleed. Eventually, Mr. Fitzwater was bleeding so much from these lung disease induced bleeds that it was impossible to keep him stabilized. According to Dr. Houser, Dr. Smith, and the physicians treating Mr. Fitzwater at the University of Virginia, he was bleeding to death. Claimant's Exhibit 3 at 59, Claimant's Exhibit 5 at 52, Director's Exhibit 16 at 3. Mr. Fitzwater was going to die unless something was done to stop the bleeding. The only option available was to stop his anti-coagulants and cauterize the AVMs. Unfortunately, if Mr. Fitzwater was taken off of this medication to cauterize the AVMs, he ran a serious risk of developing a clot on his artificial valve, and ultimately dying from a stroke or embolism. Mr. Fitzwater was in a classic 'catch twenty two.' If he stayed on his medicine he

was going to bleed to death. If he went off his medicine to cauterize his AVMs, he ran a serious risk of dying from the clot that would likely develop. Ultimately, he chose to go off his medicine and try to stop the bleeding. Unfortunately, he did develop a clot, and suffered a stroke. At that point, Mr. Fitzwater's death was a foregone conclusion, so his family decided to make him as comfortable as possible and placed him on palliative care. It is true that when he finally passed away, Mr. Fitzwater's death report listed the cause of death as renal failure secondary to congestive heart failure and infective endocarditis. However, as the UVA final hospitalization records make clear none of the situation ultimately surrounding Mr. Fitzwater's death would have occurred if his lung disease had not existed. Director's Exhibit 16 at 3-9.

Because of the complexity of the situation, the course leading to Mr. Fitzwater's death can be broken down into three sequential steps:

- Mr. Fitzwater's lung disease caused cor pulmonale
- A combination of the lung disease and cor pulmonale caused AVM bleeds
- The AVM bleeds forced a decision that resulted in Mr. Fitzwater's death

Each of these step is fully supported by the record, and will be explained in turn.

i. Mr. Fitzwater's Lung Disease Caused Cor Pulmonale

Cor Pulmonale is an "enlargement of the right ventricle, parentheses, dilation and/or hypertrophy, due to increased right ventricular afterload from diseases of the lungs or pulmonary circulation." Claimant's Exhibit 5 at 20. It should be noted at the outset that this definition completely excludes any right-sided heart disease that is caused by anything other than lung disease. With the exception of Dr. Rosenberg all of the doctors providing a reasoned medical

opinion accept this definition. See Claimant's Exhibit 5 at 20, Claimant's Exhibit 3 at 19-20, Employer's Exhibit 12-18, 23. One of the primary causes of cor pulmonale is chronic hypoxemia, which is a low level of oxygen in the arterial blood. Claimant's Exhibit 5 at 19. Both Dr. Houser and Dr. Smith concluded that Mr. Fitzwater's coal dust induced lung disease caused him to have cor pulmonale. Claimant's Exhibit 4 at 4, Claimant's Exhibit 8. They base this conclusion on several factors. First, Mr. Fitzwater underwent echocardiograms that showed the presence of right-sided heart disease despite entirely normal left ventricular and valvular function. Claimant's Exhibit 3 at 19, Claimant's Exhibit 1 at 81. Later, additional echoes would show right ventricular enlargement with decreased right ventricular function. Claimant's Exhibit 3 at 20. These test results demonstrate the presence of cor pulmonale because they show damage to the right side of the heart, without any significant effect on the left. Second, Mr. Fitzwater was diagnosed with CWP and extensive pulmonary emphysema, as well as the pulmonary hypertension and chronic hypoxemia that resulted from these diseases. Claimant's Exhibit 5 at 46. Either CWP or emphysema could account for the presence of cor pulmonale. Both together create an even higher risk for the development of the disease. *Id.* Third, Mr. Fitzwater's ABG values show exactly the type of chronic hypoxemia and pulmonary hypertension that are associated with cor pulmonale. See e.g. Claimant's Exhibit 5 at 15, 19-20; Claimant's Exhibit 1 at 380. Dr. Lopes' findings from Mr. Fitzwater's autopsy also establish a finding of cor pulmonale. These results show a right ventricle that was both enlarged and dilated. Claimant's Exhibit 8, Claimant's Exhibit 5 at 44-45. When lung disease causes pulmonary hypertension it creates elevated pressure in the right ventricle, which produces right ventricle dilation as well as some thickening. Claimant's Exhibit 5 at 25. Both conditions were present in Mr. Fitzwater. See Claimant's Exhibit 8.

Of course, Employer's experts disagree with this assessment. It should be noted however, that for the same reasons as mentioned in sections (a)(2)(i), (ii) above, the opinions of Employer's experts should be given less weight than the opinions of Claimant's experts. In addition, quite aside from the inferior source of these opinions, the opinions themselves do not enjoy the same support in the record as Dr. Houser and Dr. Smith. As mentioned in previous sections, Drs. Hippensteel and Rosenberg do not even agree that Mr. Fitzwater had a lung impairment. They state that everything going on in his system is attributable to left sided heart failure. Employer's Exhibit 3 at 10, Employer's Exhibit 6 at 11-12. They claim that the CWP and emphysema that were present in Mr. Fitzwater were inadequate to cause cor pulmonale because it was insufficient to affect the capillary bed. Employer's Exhibit 3 at 10, Employer's Exhibit 6 at 20. This assessment clearly overlooks the fact that the emphysema found upon autopsy was *diffuse*, which is to say that it was extensive and severe. Claimant's Exhibit 5 at 31. Only 10 to 20 percent of the capillary bed needs to be affected in order produce pulmonary hypertension sufficient to cause cor pulmonale. *Id.* at 25. In the present case there was not only diffuse emphysema but also CWP sufficient to cause scarring. *Id.* at 41. Together, both diseases were certainly capable of producing cor pulmonale. *Id.* at 46.

Dr. Rosenberg states that the majority of the right-sided heart disease is to be blamed on pulmonary hypertension and diastolic dysfunction. Employer's Exhibit 3 at 10. He also attributes some blame to Mr. Fitzwater's restrictive pericarditis and sleep apnea. *Id.* Dr. Rosenberg does not, however, point to anything explaining why he thinks these diseases are the cause. Furthermore, even the studies he uses to support his basic assertions do not say what he claims. Employer's Exhibit 3 at 10. He makes an assertion that an aortic valve replacement surgery can cause diastolic dysfunction. *Id.* Neither of the articles he cites stands for this

proposition. *Id.* Both articles deal with a *correlation* between diastolic dysfunction and a certain surgical anomaly, but neither article suggests that the surgery can actually cause diastolic dysfunction. The articles only recognize such a correlation when the surgery has resulted in a patient-prosthesis mismatch, and no matter what Dr. Rosenberg tries to imply, there is absolutely no evidence to suggest that a mismatch occurred with Mr. Fitzwater.

Dr. Rosenberg also claims that the article by Dr. Oudiz supports the conclusions that diastolic dysfunction leads to right sided heart failure, that aortic stenosis causes diastolic dysfunction, that pericardial fibrosis leads to pulmonary hypertension, and that sleep apnea leads to pulmonary hypertension. *Id.* The article never mentions pericardial fibrosis or sleep apnea. Further, though the article does discuss the connections between diastolic dysfunction, aortic stenosis, left sided heart failure, and right sided heart failure, it never comes close to stating that aortic stenosis causes left ventricular heart disease, or that diastolic dysfunction causes right sided heart failure. On the contrary, the article makes some allusions to the possibility that a dilated right ventricle physically impairing the left ventricle.

Diastolic dysfunction is an inadequate and incomplete explanation for Mr. Fitzwater's cor pulmonale. Claimant's Exhibit 5 at 45-46. It is inadequate because by definition, cor pulmonale is caused by lung disease. Even if that were not the case, blaming everything on left sided heart failure would completely overlook two strong pulmonary causes for the illness. *Id.*

Furthermore, for the right sided failure to have been caused by left sided failure, something would have to malfunction on the left side first. Employer's Exhibit 3 at 10. The first time that Mr. Fitzwater was diagnosed with cor pulmonale demonstrates that the echo showed right side dysfunction, but that there was normal left ventricular function. Claimant's Exhibit 1 at 81.

Eventually there was some damage done to the left side of the heart, as evidenced by the

thickened walls found at autopsy. See Director's Exhibit 15. However, the right sided failure definitely started first, there was evidence of normal left ventricular function right up until Mr. Fitzwater's death, and even taking the thickened left atrium into account, the autopsy findings are entirely consistent with cor pulmonale. Id at 3, Claimant's Exhibit 5 at 44.

Dr. Rosenberg's attribution to sleep apnea, restrictive pericarditis, and aortic stenosis are red herrings as well. Sleep apnea can only cause heart problems when it is not being successfully treated. Employer claims that Mr. Fitzwater was not being compliant with his apnea treatments. But that assertion is based on a single notation, by one doctor who only saw Mr. Fitzwater once. Dr. Smith, who saw Mr. Fitzwater regularly, testified that Mr. Fitzwater was compliant with his treatments. Employer's Exhibit 3 at 38. Finally, Mr. Fitzwater's restrictive pericarditis is not capable of causing cor pulmonale because as a heart condition restrictive pericarditis simply cannot cause cor pulmonale.¹ Also Mr. Fitzwater's pericarditis had been treated, and a disease that has been successfully treated should not be causing any problems to anyone. Id. Dr. Rosenberg attempts to claim the pericarditis was never fully repaired, but Dr. Smith, who was again, intimately familiar with Mr. Fitzwater's history and treatment, stated that the repair was entirely successful.

The opinion of Dr. Hippensteel is largely the same as Dr. Rosenberg's and falls victims to the same flaws. Employer's Exhibit 4, Employer's Exhibit 6. Put simply, there are no good, consistent explanations for the cause of Mr. Fitzwater's cor pulmonale.

ii. Mr. Fitzwater's Cor Pulmonale caused his AVMs to bleed

¹ "... the definition of cor pulmonale excludes right ventricular abnormalities secondary to left heart failure or congenital heart disease." Claimant's Exhibit 5 at 20.

Dr. Houser and Dr. Smith agree that the bleeding through Mr. Fitzwater's AVM's was made significantly worse as a result of his lung disease. The pulmonary hypertension and cor pulmonale caused by Mr. Fitzwater's coal dust induced lung disease increased the systemic venous pressure, which in turn forced the blood to flow more freely through the AVMs. Dr. Rosenberg agrees that this increase in pressure would have caused the AVMs to bleed. Employer's Exhibit 7 at 35-36.

iii. Mr. Fitzwater's lung disease induced intestinal bleeding caused Mr. Fitzwater's death

After Mr. Fitzwater's cor pulmonale and pulmonary hypertension increased the systemic venous pressure high enough to cause substantial bleeding, it placed Mr. Fitzwater in a very dangerous situation. As a result of the increased venous pressure, and the anti-coagulants that he was on, it became impossible for the doctors to maintain a balance between the bleeding in his intestine and therapeutic anti-coagulation. Director's Exhibit 16 at 3. Mr. Fitzwater was therefore forced to choose. He had to risk going off his medicine and possibly developing a blood clot, or else do nothing and bleed to death. *Id.* Mr. Fitzwater and his family chose to risk withdrawing the anti-coagulant, and within twenty four hours Mr. Fitzwater developed a clot that caused the stroke; bringing him to the point of death. Claimant's Exhibit 3 at 24-25. If it had not been for the cor pulmonale, caused by Mr. Fitzwater's coal dust induced lung disease, he would not have had such high venous pressure, his AVMs would not have been able to bleed so profusely, and it would not have been necessary for Mr. Fitzwater to go off of his anti-coagulation medicine. Claimant's Exhibit 3 at 23-25, Director's Exhibit 16.

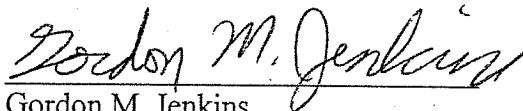
VI. Conclusion

For the forgoing reasons, Mrs. Fitzwater is entitled to Black Lung Benefits as a surviving widow.

Respectfully submitted,



Timothy C. MacDonnell, Esquire
Counsel for the Claimant



Gordon M. Jenkins
Student Caseworker

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CERTIFICATE OF SERVICE


I hereby certify on this day, August 2, 2012, a copy of the foregoing Claimant's Closing Argument was sent to the following parties of record:

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Counsel for Claimant

COPY

**UNITED STATES DEPARTMENT OF LABOR
OFFICE OF ADMINISTRATIVE LAW JUDGES**

In the Matter of:

PATRICIA F. FITZWATER, Widow
of JACKIE L. FITZWATER,

Claimant,

v.

WESTMORELAND COAL COMPANY,

Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

Case No. 2010-BLA-05364

PAGES: 1 through 42

PLACE: Beckley, West Virginia

DATE: April 17, 2011

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Party-in-Interest.

Case No. 2010-BLA-05364

City Hall
Council Chambers
South Kanawha Street
Beckley, West Virginia

Tuesday,
April 17, 2012

The above entitled matter came on for hearing
pursuant to notice, at 9:30 a.m.

BEFORE: HONORABLE LYSTRA J. HARRIS
Administrative Law Judge

Bayley Reporting, Inc.
(727) 585-0600

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I N D E X

<u>CLAIMANT'S WITNESSES</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>	<u>RECROSS</u>
Vanessa Pardue	26	36		
<u>EMPLOYER'S WITNESSES:</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>	<u>RECROSS</u>
None				

E X H I B I T S

<u>EXHIBIT</u>	<u>IDENTIFIED</u>	<u>IN EVIDENCE</u>	<u>WITHDRAWN</u>
<u>CLAIMANT'S</u>			
1	9	39	
2 through 8	9	18	
<u>EMPLOYER'S</u>			
1 through 7	16	19	
<u>DIRECTOR'S</u>			
1 through 40	9	11	
<u>ALJ'S</u>			
1 and 2	9	9	

1 P R O C E E D I N G S

2 April 17, 2012

9:30 A.M.

3 JUDGE HARRIS: Good morning. This is a hearing
4 in the matter of Patricia A. Fitzwater, Surviving Spouse of
5 Jackie L. Fitzwater versus Westmoreland Coal Company and
6 Director, Office of Workers' Compensation Programs, case
7 number 2010-BLA-05364 before the United States Department of
8 Labor, Office of Administrative Law Judges pursuant to a
9 Notice of Hearing which I issued to the parties on January
10 5, 2012. This matter involves a claim for benefits under
11 Title IV of the Federal Coal Mine Health and Safety Act of
12 1969 as amended which can be found at Chapter 30 of the
13 United States Code, Section 901 and following.

14 My name is Lystra A. Harris. I am an
15 administrative law judge with the Department of Labor and I
16 have been assigned to conduct this hearing and to make a
17 decision in this case. Would counsel for the Claimant
18 enter your appearance by stating your full name, address and
19 telephone number, please? Thank you.

20 MR. MACDONNELL: Yes, my name is Tim
21 MacDonnell, counsel for the Claimant. My address is Room
22 106, Sydney Lewis Hall, Lexington, Virginia 24450. I'm the
23 director of the Washington and Lee Black Lung Clinic,
24 telephone number 540-458-8224. I am also joined by Mr. Chaz
25 Klaes and Ms. Britteny Jenkins who are third year students

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1 working in the Black Lung Clinic and with the court's
2 permission, they will be conducting the hearing today.

3 JUDGE HARRIS: Thank you and permission is so
4 granted. I take it, there's no objection?

5 MR. MATTINGLY: There is no objection.

6 JUDGE HARRIS: All right. Would counsel for the
7 Employer please enter your appearance, please?

8 MR. MATTINGLY: On behalf of the named Employer,
9 Westmoreland Coal Company, I am William S. Mattingly. I am
10 a member of the law firm Jackson Kelly, PLLC. My mailing
11 address is P.O. Box 619, Morgantown, West Virginia 26501,
12 telephone number, 304-284-4110.

13 JUDGE HARRIS: Thank you. Referring the parties
14 to what appears as Director's Exhibit or DX Number 38 which
15 lists the issues that are in dispute in this matter, is the
16 Employer prepared to withdraw its controversion of any of
17 the issues as referenced in that exhibit?

18 MR. MATTINGLY: With regard to that exhibit,
19 there is a question as to the length of coal mine employment
20 that the Office of Workers' Compensation Programs found a
21 total of 38 and a half years. I can agree to at least 29
22 years of coal mine employment and the employment I'm not
23 stipulating to is employment with Lady H that followed the
24 employment with Westmoreland, the employment with Lady H
25 occurring 1986 to 1994. The autopsy in this case

1 established the existence of pneumoconiosis, however, some
2 physicians have concluded that it was not proven so I'm
3 going to continue to preserve the issue of pneumoconiosis
4 and causal relationship. Total ---

5 JUDGE HARRIS: I'm sorry, go ahead.

6 MR. MATTINGLY: Total disability is checked as
7 an issue. This is a survivor's claim so I don't think total
8 disability really is an issue. However, right underneath
9 that is partial disability which refers to Section 411(C)(5)
10 of the Act which is really 30 USC Section 921 and that
11 portion of the Act through the PPACA does apply to this
12 survivor's claim given the time that it was filed preserving
13 objection to the application of that. Disability is an
14 issue for invocation of that presumption, 15 years
15 employment in the survivor's claim.

16 Death causation is an issue I'll continue to
17 contest. I don't have anything to challenge the status of
18 Mrs. Fitzwater as an eligible survivor. So, that issue can
19 be withdrawn. I will continue to preserve the responsible
20 operator issue and will brief that. The additional issues
21 are a challenge to the constitutionality of the Act and the
22 regulations and the application of the PPACA in any fashion
23 to this case, but the Supreme Court will hopefully resolve
24 that for all of us before June.

25 JUDGE HARRIS: Thank you. For the Claimant,

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1 with regard to the proposed stipulations as I understand as
2 stated by Mr. MacDonnell, the Employer is willing to agree
3 to at least 29 years of coal mine employment. Is that
4 correct?

5 MR. MATTINGLY: That's correct.

6 JUDGE HARRIS: And also is willing to agree that
7 the Claimant is an eligible survivor as defined by the
8 pertinent regulations.

9 MR. MACDONNELL: Yes, Your Honor, one question
10 that was raised by Mr. Mattingly is the question of the
11 relevance of total disability and I think I understood him
12 such that we would agree. We believe total disability is
13 relevant as it relates to the PPACA. In the event this
14 court were to find that Mr. Fitzwater was totally disabled
15 from a pulmonary standpoint at the time of his death and
16 that he worked for more than 15 years for an underground
17 coal mine, Mrs. Fitzwater would be entitled to the
18 rebuttable presumption that death in this case was caused by
19 his coal mine employment.

20 JUDGE HARRIS: All right.

21 MR. MACDONNELL: Further, in conversations with
22 Mr. Mattingly before we had requested a stipulation that the
23 coal mine that Mr. Fitzwater worked at was an underground
24 coal mine and I believe we came to an agreement on that, but
25 I'll leave that to Mr. Mattingly.

1 MR. MATTINGLY: Yes, I can agree that he worked
2 as an underground coal miner.

3 JUDGE HARRIS: For the 29 years to which ---

4 MR. MATTINGLY: Yes.

5 JUDGE HARRIS: All right. So, once again, I'm
6 trying to get some clarity, I appreciate that, some clarity
7 as to the other matters to which the parties agree that does
8 the Claimant join in the stipulation of at least 29 years of
9 underground coal mine employment and that the Claimant is an
10 eligible survivor? I assume that those are acceptable.

11 MR. MACDONNELL: Of course, Your Honor, however,
12 we believe the record will support the 38 and a half years
13 of coal mining. So, it's a floor not a ceiling from the
14 Claimant's prospective.

15 JUDGE HARRIS: Okay and I should note for the
16 record that the Director, Office of Workers' Compensation
17 Programs, is not represented at this proceeding. Prior to
18 the convening of this hearing, both parties did submit their
19 evidence summary forms, the completed evidence summary
20 forms. I will mark and receive them as the Claimant's
21 evidence form as Administrative Law Judge Exhibit 1 and the
22 Employer's final evidence summary form as Administrative Law
23 Judge Exhibit 2.

24 //

25 //

1 (Whereupon, the documents referred
2 to were marked for identification
3 as ALJ's Exhibits 1 and 2.)

4 (Whereupon, the documents marked
5 for identification as ALJ's
6 Exhibits 1 and 2 were admitted into
7 evidence.)

8 JUDGE HARRIS: The Director has also forwarded
9 documents marked as Director's Exhibits 1 through 40
10 including the cover sheet for inclusion in the record
11 pursuant to Section 725.456(A). Do the parties have any
12 objection to the admission of those Director's Exhibits, Mr.
13 Mattingly?

14 (Whereupon, the documents referred
15 to were marked for identification
16 as Director's Exhibits 1 through
17 40.)

18 MR. MATTINGLY: Judge, I don't have any objection
19 to the Director's Exhibits 1 through 40, however, as a
20 matter of clarification, the miner's claim is included
21 before Director's Exhibit 1 and there is medical evidence
22 that is included with that. I think you should take
23 judicial notice of the procedural posture of that claim, the
24 fact that it was a denied miner's claim because we need that
25 information now for this survivor's claim, but as far as the

1 medical evidence, it should not be included unless the
2 parties designate it as part of their affirmative cases.

3 JUDGE HARRIS: Well, I don't have the file in
4 front of me presently. I did review it prior, but I don't
5 believe the miner's claim is just tabbed and precedes the
6 exhibits presented by the Director and certainly, no
7 procedural posture of the miner's claim, but the law
8 requires that any medical evidence related to that claim
9 must be specifically offered by the Claimant, the surviving
10 spouse in this matter, if it is her intention to have that
11 evidence considered by me. So, duly noted, Mr. Mattingly.
12 So, absent that, there is no objection to what has been
13 marked as Director's Exhibits 1 through 40?

14 MR. MATTINGLY: That is correct.

15 JUDGE HARRIS: Exclude which in Director's
16 Exhibit 1, does not constitute the deceased miner's claim.

17 MR. MATTINGLY: That's correct and I have no
18 objection to those 40 exhibits.

19 JUDGE HARRIS: All right. Mr. MacDonnell?

20 MR. MACDONNELL: No objection, Your Honor.

21 JUDGE HARRIS: Director's Exhibits 1 through 40
22 are so admitted.

23 //

24 //

25 //

1 (Whereupon, the documents marked
2 for identification as Director's
3 Exhibits 1 through 40 were admitted
4 into evidence.)

5 JUDGE HARRIS: All right. Turning to the
6 Claimant's evidence summary form, Claimant is offering
7 exhibits the Claimant's Exhibits from CX-1 through 8. Is
8 that correct?

9 (Whereupon, the documents referred
10 to were marked for identification
11 as Claimant's Exhibits 1 through
12 8.)

13 MR. KLAES: Yes, Your Honor, that is correct.

14 JUDGE HARRIS: All right. Do you want to
15 outline for me, Mr. Klaes what those exhibits are or Ms.
16 Jenkins?

17 MS. JENKINS: Now, Claimant's Exhibit 1 is the
18 treatment record of Dr. Lynn Smith.

19 Claimant's Exhibit 2 which is also Director's
20 Exhibit 18, that's a letter from Dr. Lynn Smith and medical
21 report dated December 31, 2008.

22 Claimant's Exhibit 3 is a deposition by Dr. Lynn
23 Smith that was conducted on February 29, 2012.

24 Claimant's Exhibit 4 is a recent medical opinion
25 of Dr. William Houser and that's dated February 15, 2012.

1 Claimant's Exhibit 4A through Claimant's Exhibit
2 4E, these are all references used by Dr. Houser and were
3 included in his recent medical report that we attached in
4 his recent medical report here today to be submitted.

5 Claimant's Exhibit 5, that's the deposition of Dr.
6 William Houser and that took place March 22, 2012.

7 Claimant's Exhibit 6 which is also Director's
8 Exhibit 16 formerly are the treatment records from the
9 University of Virginia Hospital.

10 Claimant's Exhibit 7 is a death certificate by Dr.
11 Molly McShane which was issued, excuse me, September 29,
12 2008 and lastly, Claimant's Exhibit 8 which is also
13 Director's Exhibit 15 and that's the autopsy report by Dr.
14 Lopez which was dated September 25, 2008.

15 JUDGE HARRIS: Thank you. All right, Mr.
16 Mattingly, does the Employer have any objection to the
17 admission of Claimant's 1 through 8?

18 MR. MATTINGLY: Claimant's 2, 6 and 8 are
19 duplicative, but does have that explained on the record.
20 I'm not sure why we need duplicate copies, but I don't raise
21 any objection to those. I have no objection for Claimant's
22 Exhibits 2 through 8. However, with regard to Claimant's
23 Exhibit 1 and I guess as way of demonstration, I divided it
24 and brought it to you this morning. There are 1,040 pages
25 that have been offered as Claimant's Exhibit 1. I've got

1 them in two black binders. To be received in evidence under
2 Section 725.414, treatment records have to be relevant to
3 the treatment or diagnosis of a pulmonary or respiratory
4 condition which makes sense because those are the issues
5 that you have to consider to resolve the case. I have no
6 objection to Claimant's Exhibit 1, pages 1 through 402.
7 Some of those are treatment records from UVA, some are from
8 other facilities, some of them are clinic visits from the
9 treating physician, Dr. Smith. Those, I think, are
10 relevant. I have no objection to page 964 which is arterial
11 blood gas study from March of 1999. However, with the
12 exception of that page, pages 403 or through 1,040 are
13 clinical results, laboratory results that measure a whole
14 series of blood chemistries, cholesterol levels, monitoring
15 for Coumadin and blood thinners. They're just ---

16 JUDGE HARRIS: So, in essence, you're arguing
17 relevance and that it was not allowed on the regulations ---

18 MR. MATTINGLY: Yes.

19 JUDGE HARRIS: -- to succinctly put it?

20 MR. MATTINGLY: They're not going to help you
21 resolve this case.

22 JUDGE HARRIS: All right.

23 MR. MATTINGLY: The physicians just don't need
24 that information.

25 JUDGE HARRIS: Fair enough. I think the

1 Employer's objection is fair enough and well stated for the
2 record. Ms. Jenkins, do you wish to respond briefly?

3 MR. MACDONNELL: Actually, it's going to be Mr.
4 Klaes. I'm sorry to keep moving around.

5 JUDGE HARRIS: Mr. Klaes, I'm sorry.

6 MR. KLAES: Your Honor, these records are
7 relevant because they show that Mr. Fitzwater was on
8 Coumadin for nine years to prevent strokes. These records
9 show that Mr. Fitzwater was compliant with his Coumadin
10 requirements and remained in range on every one of these
11 reports. Your Honor, these records show that Mr. Fitzwater,
12 as soon as he was taken off Coumadin to stop the bleeding
13 that was caused by his lung disease, he had a stroke. These
14 records are relevant because they show that his lung disease
15 was a significant contributing factor in his death.
16 Furthermore, Your Honor, Employer's counsel acknowledged the
17 relevancy of these during the deposition of Dr. Smith when
18 he cross examined Dr. Smith about whether Mr. Fitzwater's
19 Coumadin requirements required any tinkering.

20 Your Honor, these records are also relevant
21 because the Employer contends that Mr. Fitzwater was non-
22 compliant with some of his treatment regimens. They show
23 that he was compliant with his Coumadin dosages. They show
24 that he was compliant with his diabetes treatment which is
25 an issue raised by Dr. Rosenberg. Your Honor, these records

1 are relevant because they show that his lung disease is a
2 direct contributing factor in his death which is a central
3 issue and contention at this hearing.

4 JUDGE HARRIS: Thank you, Mr. Klaes. All right,
5 I've heard the Employer's position with regard to a portion
6 of what has been marked as Claimant's Exhibit 1 which is, as
7 I understand it, Mr. Mattingly, you do object to, the
8 Employer objects to page --- has no objection, it's easier
9 to put it that way, has no objection to Claimant's 1, pages
10 1 through 402. Have they been Bates stamped so I'll be able
11 to follow along with this pagination reference?

12 MR. KLAES: Yes.

13 JUDGE HARRIS: And no objection to page 964, but
14 everything else the Employer contends should be excluded
15 from the record in this matter for lack of relevance and
16 because it is unrelated to any respiratory or lung
17 condition. That's the Employer's position and the Claimant
18 contends that it is relevant, the treatment records in their
19 entirety relevant to the issue of causation in this matter,
20 so simply put. I'm going to reserve ruling on the admission
21 of that part of Claimant's Exhibit 1 to which objection has
22 been raised. I will advise the parties of my ruling in an
23 order separate and distinct from my decision as issued in
24 this matter and will do so in a time frame that will allow
25 the parties to address the evidence of record in this case

1 properly and any closing submissions. So, the Employer
2 intends to offer evidence in this matter as indicated in its
3 evidence summary form. Is that correct, Mr. Mattingly?

4 MR. MATTINGLY: That is correct. I have seven
5 exhibits. Would you like me to identify them for the
6 record?

7 (Whereupon, the documents referred
8 to were marked for identification
9 as Employer's Exhibits 1 through
10 7.)

11 JUDGE HARRIS: Sure.

12 MR. MATTINGLY: Employer's Exhibit 1 is an
13 autopsy review report by Dr. Stephen T. Bush and Dr. Bush's
14 curriculum vitae.

15 Employer's Exhibit 2 is reports of Dr. Lapp and
16 Franke interpreting the x-ray taken January 22, 1981 and
17 pulmonary function with arterial blood gas studies that were
18 done October 24, 1979 and January 22, 1981 with those
19 physicians' curriculum vitae and those were from the prior
20 miner's claim.

21 Employer's 3 is the independent medical report by
22 Dr. David M. Rosenberg and Dr. Rosenberg's curriculum vitae.

23 Employer's 4 is an independent medical report by
24 Dr. Kirk Hippensteel and his curriculum vitae.

25 Employer's 5 is an employment history from

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1 Westmoreland Coal Company.

2 Employer's 6 is the deposition the parties took of
3 Dr. Hippensteel on March 30, 2012.

4 Employer's 7 is the deposition with attachments
5 that the parties took of Dr. Rosenberg on April 9, 2012.
6 I've offered the complete deposition, however, I don't
7 understand why Claimant wanted to attach five medical
8 articles to Dr. Rosenberg's deposition that were never asked
9 any questions to Dr. Rosenberg. He cited these in his
10 report, but he was never cross examined so I don't know that
11 they're entirely relevant. So, I would object to that
12 portion of my own exhibit.

13 JUDGE HARRIS: I was going to say ---

14 MR. MATTINGLY: Yes, but because they were
15 attached to the deposition by the other party, I just
16 attached them to the part of the deposition and would
17 explain what happened and why I'm objecting to the relevance
18 today. So, I have these seven exhibits for you.

19 JUDGE HARRIS: Okay, great. Thank you.

20 MR. MACDONNELL: Your Honor, on the relevance
21 question, do you want us to address it?

22 JUDGE HARRIS: Just one moment, Mr. MacDonnell.
23 Thank you. In Claimant's, just so the record could be
24 clear, there's no objection on the Employer's part to
25 Claimant's 2 through 8 other than you made note of the

1 duplicative nature of some of the exhibits offered, but
2 aside and apart from that, there are no objections?

3 MR. MATTINGLY: That's correct.

4 JUDGE HARRIS: Claimant's 2 through 8 are so
5 admitted and the Claimant ---

6 (Whereupon, the documents marked
7 for identification as Claimant's
8 Exhibits 2 through 8 were admitted
9 into evidence.)

10 MR. MACDONNELL: Just to keep it lively, Your
11 Honor.

12 JUDGE HARRIS: All right. So, we're now going
13 to address Employer's Exhibits 1 through 7. Mr. MacDonnell?

14 MR. MACDONNELL: Your Honor, we have no
15 objection to 1 through 7. We did request that those reports
16 be included in or attached to the deposition. Dr. Rosenberg
17 cited to those reports himself and those studies in his
18 report. It's our position those studies do not support the
19 propositions for which he cited them so we wanted them
20 included in the deposition.

21 MR. MATTINGLY: And Judge, there's no basis for
22 a lay person to look at the medical study, to try to discern
23 from it whether or not it supports what Dr. Rosenberg may
24 have indicated. Doctors don't cite medical articles the
25 same way that lawyers cite cases. He has interpreted the

1 article to stand for a proposition. If they wanted to cross
2 examine that the articles didn't stand for that medical
3 proposition, the proper procedure would have been to have an
4 expert physician make that statement. They as lawyers or
5 law students can't look at the articles and say, "It doesn't
6 support Dr. Rosenberg's opinion".

7 JUDGE HARRIS: Fair enough. I will allow
8 Employer's Exhibits 1 through 7 and all the evidence that is
9 received in this matter will be given its appropriate
10 weight.

11 (Whereupon, the documents marked
12 for identification as Employer's
13 Exhibits 1 through 7 were admitted
14 into evidence.)

15 JUDGE HARRIS: Because this claim, surviving
16 spouse claim was filed when it was is governed by the
17 amended regulations of 20 CFR Part 718 and 725 and
18 accordingly, the parties are limited in their evidentiary
19 submissions pursuant to 20 CFR Section 725.414. Therefore,
20 I am advising the parties that I will consider only that
21 evidence formally admitted and if the admitted evidence
22 contains any medical data in excess of the limitations as
23 outlined in the pertinent regulations. I will consider
24 myself bound by the evidence designations delineated on the
25 evidence summary form submitted by the parties today.

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1 As for Claimant's 1 through 8, is there a set of
2 those for me?

3 MR. MACDONNELL: Yes, Your Honor.

4 JUDGE HARRIS: What I'm going to ask after I
5 look through them, but as both parties will be directed to
6 submit their exhibits to my office subsequent to this
7 proceeding because I don't want to carry it all.

8 MR. MACDONNELL: Your Honor, you want it mailed
9 to your office is what you're saying?

10 JUDGE HARRIS: Yes.

11 MR. MACDONNELL: Okay.

12 JUDGE HARRIS: I take it there will be opening
13 statements by the parties in this matter. Mr. MacDonnell,
14 who will be making the opening statement on behalf of Ms.
15 Fitzwater?

16 MR. MACDONNELL: Mr. Klaes.

17 JUDGE HARRIS: All right, Mr. Klaes, briefly
18 please.

19 MR. KLAES: Good morning, Your Honor.

20 JUDGE HARRIS: Good morning.

21 MR. KLAES: Mr. Jackie Fitzwater spent 38 and a
22 half years in our nation's coal mines. He spent his first
23 ten years underground before there were any dust
24 regulations. He spent his next 28 and a half years at the
25 tipple, an area of the mine that according to Dr. Houser, a

1 Board certified pulmonologist and an expert in black lung,
2 is just as dusty as working underground. Mrs. Fitzwater is
3 entitled to the 15-year presumption because Mr. Fitzwater
4 worked for more than 15 years at an underground coal mine
5 and suffered from totally disabling lung disease at the time
6 of his death. We will establish this last element through
7 the deposition testimony of Dr. Smith, Mr. Fitzwater's
8 treating physician for 25 years, and Dr. Houser.

9 Mr. Fitzwater suffered from chronic prolonged
10 shortness of breath and was continuously prescribed
11 bronchodilators to treat his COPD. Mr. Fitzwater was placed
12 on supplemental oxygen in 1999 and by 2004, he was
13 completely oxygen dependent. Dr. Smith testified that Mr.
14 Fitzwater was totally disabled from a pulmonary standpoint
15 and would have been unable to return to any type of job let
16 alone his last usual coal mine job as a car driver. Dr.
17 Houser also testified that Mr. Fitzwater was totally
18 disabled from a pulmonary standpoint.

19 Mrs. Fitzwater is entitled to the 15-year
20 presumption. As such, this court should presume that coal
21 mine dust hastened Mr. Fitzwater's death unless the
22 Employer's experts can rule out coal mine dust as a
23 contributing factor. They cannot do so. There are over 20
24 years of medical records in this case including arterial
25 blood gas studies, x-rays and treatment notes to show that

1 Mr. Fitzwater suffered from significant lung disease despite
2 the conclusions of the Employer's experts, Dr. Hippensteel
3 and Rosenberg. At autopsy, Mr. Fitzwater had both clinical
4 coal workers' pneumoconiosis and coal mine dust induced
5 emphysema. Dr. Lopez, a Board certified pathologist, and
6 the head of autopsy at UVA conducted an autopsy performing a
7 gross and microscopic examination of the lungs and found
8 both clinical coal workers' pneumoconiosis and diffuse
9 emphysema.

10 The evidence shows that Mr. Fitzwater smoked.
11 That was only one factor that contributed to his lung
12 disease. Both Dr. Smith and Dr. Houser agree that his
13 smoking and his nearly 40 years of coal mining significantly
14 contributed to his lung disease. Dr. Houser, Dr. Smith, Dr.
15 Rosenberg and numerous doctors at UVA diagnosed Mr.
16 Fitzwater with Cor Pulmonale. By definition, Cor Pulmonale
17 according to Dr. Smith, Dr. Houser, Dr. Hippensteel and
18 Steadman's Medical Dictionary is right-sided heart failure
19 that results from lung disease. His Cor Pulmonale caused
20 increased venous pressure. His increased venous pressure
21 caused him to breathe through what are called AVNs in his
22 G.I. tract. During his last hospitalization at UVA, the
23 doctors were unable to reach a balance between his bleeding
24 which according to Dr. Houser, he was bleeding to death and
25 his Coumadin requirements. The family decided to take him

1 off Coumadin to stop the bleeding and he had a stroke. At
2 that point, the doctors told the family there was nothing
3 else they could do. So, the family decided to only continue
4 with comfort care. Mr. Fitzwater died two days later.

5 Mr. Fitzwater's coal mine dust induced lung
6 disease hastened his death. Your Honor, at the close of
7 evidence, we will ask that you award Mrs. Fitzwater federal
8 black lung benefits. Thank you.

9 JUDGE HARRIS: Thank you, Mr. Klaes. Mr.
10 Mattingly, does the Employer wish to make a brief opening
11 statement?

12 MR. MATTINGLY: Certainly, I'll offer a
13 response. Black lung cases are frequently interesting.
14 This one is fascinating from a medical standpoint. Mr.
15 Fitzwater's medical history reveals that he literally
16 received state of the art care that kept him alive for
17 years. What you didn't hear in the opening statement was
18 the autopsy report found very little pneumoconiosis. Two
19 other pathologists looked at it and disagreed whether it was
20 just black pigmentation or whether he actually had macules,
21 the early formation stage of pneumoconiosis shown in the
22 lungs, but the treatment records from UVA square much better
23 and support the conclusions of Drs. Hippensteel and Dr.
24 Rosenberg than they do the other physicians in this case.

25 This gentleman had significant cardiac problems.

1 He had aortic stenosis which required a replacement of a
2 valve and that happened in the 1990's and from there, his
3 cardiac care at UVA was state of the art and they simply
4 kept him alive for years, but he had major complication
5 after complication.

6 Cor Pulmonale can be caused by lung disease, but
7 it can also be caused by other cardiac conditions. In this
8 case, he developed pericarditis, an inability of the heart
9 within the pericardial sac which protects the heart to have
10 the right size and that pericardial sac had to be stripped.
11 It had to be made smaller so his heart could literally beat
12 in his chest. That's what caused in combination with the
13 aortic stenosis the right-sided cardiac changes. They
14 weren't due to lung disease. Dr. Hippensteel and Dr.
15 Rosenberg explained why the treatment records from UVA
16 helped them reach this conclusion. The bleeding disease was
17 unrelated to any lung disease and the bleeding disease, the
18 AVMs is part and parcel to syndrome that developed as a
19 result of the aortic stenosis.

20 So, although this man may have had very minimal
21 simple coal workers' pneumoconiosis discernable at autopsy
22 and really not seen during his lifetime, it played no role
23 in any shape in causing or hastening his death. So, Mrs.
24 Fitzwater is not entitled to lifetime survivor's benefits.

25 JUDGE HARRIS: Thank you. Claimant's counsel,

1 please call your first witness.

2 MS. JENKINS: We call Ms. Vanessa Pardue.

3 JUDGE HARRIS: Good morning.

4 MS. PARDUE: Good morning.

5 MS. JENKINS: Good morning.

6 JUDGE HARRIS: Just one moment before you begin.

7 I want to make sure this has evidentiary value because we
8 have to swear the witness in first.

9 MS. JENKINS: Sorry.

10 JUDGE HARRIS: No problem. Ms. Pardue, it is
11 required that all testimony taken in these matters be taken
12 either under oath or by affirmation if there is an objection
13 to taking an oath. After I administer the oath or
14 affirmation to you, I will give counsel for the Claimant an
15 opportunity to ask you some questions followed by that
16 opportunity given to counsel for the Employer. It is also
17 possible that I may have some questions for you as well. Do
18 you have any objection to taking an oath, ma'am?

19 MS. PARDUE: No, ma'am.

20 JUDGE HARRIS: You may remain seated and please
21 raise your right hand.

22 //

23 //

24 //

25 //

1 Whereupon,

2 VANESSA PARDUE

3 having been first duly sworn, was called as a witness

4 herein, and was examined and testified as follows:

5 WITNESS: Yes, ma'am.

6 JUDGE HARRIS: You may lower your hand. State
7 your full name for the record, please and spell your first
8 and last names as well.

9 WITNESS: Vanessa Gail Pardue, V-A-N-E-S-S-A P-
10 A-R-D-U-E.

11 JUDGE HARRIS: Okay, thank you. Ms. Jenkins?

12 **DIRECT EXAMINATION**

13 BY MS. JENKINS:

14 Q Good morning. What is your relationship to Mr.
15 and Mrs. Fitzwater?

16 A They are my parents.

17 Q Now, at the time of your father's death, were your
18 parents still married?

19 A Yes, ma'am.

20 Q Now, I want to talk to you a little bit about your
21 father's coal mine work. Now, how old were you when Mr.
22 Fitzwater began working in the mines?

23 A I wasn't born. I wasn't born until '57.

24 Q Now, how old were you when he stopped working in
25 the mines?

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1 A He stopped in '94 and I was born in '57. I should
2 know that, but I don't.

3 Q Now, where did you live during this time?

4 A We lived in Wesley, West Virginia.

5 Q Now, how long did Mr. Fitzwater, your father, work
6 underground in the coal mines?

7 A Ten years.

8 Q Now, what kind of jobs did he have above ground?

9 A He was a car dropper, he worked actually inside
10 the tipple at the preparation plant, he loaded trucks and
11 stuff with big equipment.

12 Q Now, after your father worked in the coal mines
13 and when he came home, what was his appearance?

14 A My dad was black from head to toe with coal dust.

15 Q Now, was he black from head to toe when he worked
16 underground in the mines?

17 A Yes, ma'am.

18 Q How about when he worked above ground, what did
19 his appearance look like?

20 A It didn't look any different to me.

21 Q Now, Mr. Fitzwater, in the record it states that
22 he had worked about approximately 38 and a half years in the
23 mines. Does that sound about right to you?

24 A Yes, ma'am, in years, yes, ma'am.

25 Q Now, how many days a week did Mr. Fitzwater work

1 in the mines?

2 A My dad could work six days a week. My dad double
3 backed which is doing his shift and staying for the other
4 shift. He worked sometimes on Sunday if required. My dad
5 worked all the time.

6 Q Now, how many hours are in a shift?

7 A Approximately eight.

8 Q And how many times would Mr. Fitzwater go on
9 vacation?

10 A Coal miners have vacation two weeks every year.
11 Most of the time, my dad would work one week of those
12 vacations in the mines. He would probably take a week a
13 year.

14 Q Now, Ms. Pardue, I want to talk to you about Mr.
15 Fitzwater and any breathing problems he had. When, if at
16 all, did you notice he had become short of breath?

17 A I noticed it probably whenever I had my first
18 child. She was born in '74. As she got older and wanted to
19 play, I noticed that my dad was resting more, slower to
20 chase after her than what I had noticed whenever I was at
21 home as a child.

22 Q Now, why was he slow to chase after her?

23 A He was short ---

24 MR. MATTINGLY: Judge, I think that calls for a
25 medical conclusion.

1 JUDGE HARRIS: Ms. Jenkins, you may respond to
2 the objection.

3 MS. JENKINS: Ms. Pardue is simply telling us
4 about her recollection of what happened when Mr. Fitzwater
5 had shortness of breath. It's not a medical opinion, Your
6 Honor, it's simply her recollection of her observation of
7 seeing her father throughout the years.

8 JUDGE HARRIS: All right, the objection is
9 overruled. I'll allow the witness to respond.

10 WITNESS: He was just slower, he rested more, he
11 took more breaks. He chose what he did and what he did not
12 do.

13 BY MS. JENKINS:

14 Q Now, over time, Ms. Pardue, do you believe that
15 Mr. Fitzwater's breathing problems got better or worse?

16 A They got worse.

17 Q Now what, if any, activities was Mr. Fitzwater not
18 able to do that he was able to do before?

19 A My dad followed West Virginia Mountaineer
20 football. He gave up his season tickets for that. He got
21 to where he could not go to the ball games. He went to the
22 races. The last race we went to, that I went to with my dad
23 was a bad choice to go. So, he gave up what he loved to do.
24 He gave up mowing grass and he gave up cleaning his car once
25 a week which included waxing and stuff. He paid people to

1 do that.

2 Q Now, let's take those one by one. You talked
3 about the West Virginia Mountaineers football games. When
4 was that game?

5 A The last one that I went to with my dad was
6 January 1997. No, excuse me, no, it wasn't, it was in the
7 fall of '97, the Marshall, West Virginia game we went to.
8 We had to take lots of rests getting him to the stadium. We
9 left early to get him back to the car before the mob
10 started. He took lots of rest, lots of breaks. We took it
11 slow.

12 Q Why did you have to take it slow?

13 A Because my dad could not walk a great distance at
14 one time.

15 Q Why couldn't he walk a great distance at one time?

16 A Because he was short of breath.

17 Q Now, Ms. Pardue, you also mentioned the
18 Martinsville races. When did those happen?

19 A That was in, I believe it was in September or
20 October, one month of '96. We went to the Martinsville
21 Nascar race.

22 Q Now, what happened during that race when you went
23 there?

24 A Where you park is in a field that's the designated
25 parking area. That was not our choice to park there and we

1 got as close as we could. The field is kind of --- it's not
2 hilly like very elevated, but it's hilly. It's down and up,
3 down and up. It took us quite a while to get him to the
4 racetrack. We took rests. It was possibly maybe a quarter
5 of a mile that we walked and we took four to five breaks in
6 between that to let him catch his breath. So, it took us
7 quite a while. Again, we left before the race was over so
8 that we could help my father back to the car and he was very
9 winded, very winded.

10 Q Now, you mentioned that Mr. Fitzwater wasn't able
11 to cut grass anymore. Now, when did that start happening?

12 A That probably started happening in the late 70's,
13 maybe early 80's. I'm not exactly sure, I wasn't home at
14 that time, but I believe that's when it was.

15 Q Okay. Now, how could you tell he was unable to
16 cut grass?

17 A Because he was paying someone to cut his grass.

18 Q Now, you also mentioned that Mr. Fitzwater liked
19 to wax cars and had to stop. Now, when did that happen?

20 A I don't know. I don't know exactly when that
21 happened. I just know that he helped me one time in '96 and
22 I had to set him on a five gallon bucket because he couldn't
23 stand to do it.

24 Q Why couldn't he stand to do it?

25 A Because he couldn't stand the motion. It winded

1 him. He lost his breath. He was very short of breath, very
2 short of breath.

3 Q Now, was there any time that you returned home
4 after leaving?

5 A Yes, ma'am, I returned home in July of 1996.

6 Q How long did you stay home?

7 A I was there until August of 1997.

8 Q And when you were home, were you able to see your
9 father on a daily basis?

10 A Everyday, I lived with my dad and mother.

11 Q Now, during that year, what, if anything, did you
12 notice about Mr. Fitzwater's health concerning his shortness
13 of breath?

14 A I noticed that my dad was very short of breath,
15 that my dad was not the same man physically whenever I was
16 at home. I seen it everyday. I seen him progressively ---
17 it wasn't something all of a sudden, it was progressively.
18 Things everyday, just very short of breath, taking lots of
19 rest, picking and choosing what he did where he could rest
20 and where he could take his time doing it.

21 Q Now, you said that after you noticed that his
22 breathing problem had begun to progress, was he on any sort
23 of medication to help him with his breathing?

24 A My father was on oxygen. I'm not sure when that
25 started, but I did see him later on take breathing

1 treatments.

2 Q So, you say he was on oxygen, you don't know how
3 long. At any point, had it become continuous?

4 A Yes, ma'am.

5 Q Okay. Now, Ms. Pardue, the last few years of Mr.
6 Fitzwater's life, now please tell us, how any sort of way he
7 would look when he would try to walk from one side of the
8 room to the other. How would he look? How would he move?

9 A Very slow. Very slow, very meticulous, trying to
10 watch every step that he took. From the bathroom to his
11 room was a struggle, maybe ten feet. It was a struggle.

12 Q Was he using oxygen a lot at this point?

13 A Yes, ma'am.

14 Q Did he --- how long?

15 A Do you mean how long he used it?

16 Q (Affirmative response)

17 A During the day?

18 Q Yes, during these few years, how long was he using
19 it?

20 A It was everyday all the time.

21 Q Now, what, if anything, did he use to help him
22 walk from place to place?

23 A He had a walker, he had a cane, he had a scooter.

24 Q Now, I want to talk to you about the last few
25 weeks of Mr. Fitzwater's life. Now, why was he at the

1 University of Virginia Hospital for that final
2 hospitalization?

3 A My dad had multiple ---

4 MR. MATTINGLY: Let me object to that question
5 because I think that clearly calls for medical conclusion
6 that's reflected in the treatment records that are already
7 in the record.

8 JUDGE HARRIS: Objection sustained. Let's move
9 on, Ms. Jenkins.

10 MS. JENKINS: Okay.

11 BY MS. JENKINS:

12 Q At the end of Mr. Fitzwater's life, could you
13 please tell us any decisions that you made concerning his
14 care?

15 A We had to make the decision to stop the Coumadin
16 in order to keep my father from bleeding to death which
17 brought on the strokes. There wasn't too much of a decision
18 to do. It was a catch 22.

19 Q What do you mean by catch 22?

20 A If we done one thing, he was going to die from
21 another. If we didn't do that one thing, he was going to
22 die from another. My dad was a walking dead man.

23 Q Why did you put him in comfort care?

24 A The doctors came to us. Actually, the doctor from
25 UVA called me at work. I was the hold out on the comfort

1 care. He called me, he explained the situation to me,
2 talked to me in depth about where we were at. So, I told
3 him that I would call my mother and my sister and we would
4 discuss it. So, we decided that in dad's best interests, he
5 had no quality of life. He could not get out of bed and
6 nothing was going to make him better so we decided to do
7 what we thought was best and that was comfort care.

8 Q Thank you, Ms. Pardue. I wanted to ask you about
9 any sort of drinking that your father did. Was he ever a
10 drinker?

11 A My father never drank in his life.

12 Q Now, I just want to ask you a few questions about
13 Dr. Smith. Now, who is Dr. Smith?

14 A Dr. Smith was my father's primary physician for 25
15 years or more.

16 Q How often would he see Dr. Smith?

17 A I guess at first, just for regular checkups, but
18 towards the end, it was two or three times a month depending
19 on how many units of blood he had to have and how often he
20 had to have it.

21 Q Now, why was he seeing Dr. Smith so regularly?

22 A My dad had bleeds in his stomach and they were
23 giving him units of blood at least every two weeks and
24 sometimes every week.

25 Q Lastly, Ms. Pardue, after your father passed away,

1 did your mother ever remarry?

2 A No, ma'am.

3 MS. JENKINS: Thank you. No further questions
4 at this time.

5 MS. MATTINGLY: Ma'am, I've just got a couple of
6 questions for you.

7 **CROSS EXAMINATION**

8 BY MR. MATTINGLY:

9 Q Your father actually had his heart valve replaced
10 in November of 1998 at UVA?

11 A Yes, sir.

12 Q And Dr. Smith was treating him for heart disease
13 prior to that surgery?

14 A I do not know.

15 Q Okay. Your father was also a cigarette smoker?

16 A Yes, sir.

17 Q Smoked somewhere around a package of cigarettes
18 per day?

19 A I do not know.

20 Q What did you observe? You lived with him.

21 A I seen him smoke cigarettes. I do not know how
22 many he smoked a day.

23 Q Okay. So, living with him between approximately
24 the years of 1996 and 1997, you saw him smoke, but you don't
25 know how much he smoked?

1 A Yes, sir, I worked during the day.

2 Q And he was at home with your mom at that time?

3 A Yes, sir.

4 Q He stopped smoking from some records around 2008,
5 2007. Is that consistent with your recollection?

6 A I do not know. I was in North Carolina at that
7 time.

8 Q But he was a smoker years after he had heart
9 surgery?

10 A I do not know that either. I do not know when he
11 quit.

12 Q Did you see him smoke in this century?

13 A Yes, sir.

14 MR. MATTINGLY: I think that's all the questions
15 I have for you, ma'am. Thank you.

16 JUDGE HARRIS: All right. Ms. Pardue, you may
17 step down. Thank you very much. All right, before the next
18 witness is called, I'd like an offer of proof as to what Ms.
19 Quillen will be testifying too.

20 MR. MACDONNELL: Actually, Your Honor, based on
21 the testimony of Ms. Pardue, we're not going to be calling
22 Ms. Quillen.

23 JUDGE HARRIS: Okay, that makes my other
24 concerns moot. The Employer is calling no witnesses. Is
25 that correct?

1 MR. MATTINGLY: That is correct.

2 JUDGE HARRIS: Okay. Now, I take it that the
3 parties wish to present written closing arguments in this
4 matter. Is that fair to say?

5 MR. MACDONNELL: Yes, Your Honor.

6 MR. MATTINGLY: Please.

7 JUDGE HARRIS: There is the matter and I should
8 note for the record that and I don't think I stated it at
9 the outset when the matter of exhibits or admission of
10 exhibits was being addressed that I will allow absent any
11 objection from the Employer, that part of Claimant's
12 Exhibits, that part of the Claimant's Exhibit 1 to which
13 there is on objection, i.e., pages 1 through 402 and page
14 964 are admitted into evidence. As to the remaining portion
15 of Claimant's 1, I reserve ruling on the admission of those
16 documents and will advise the parties of that ruling.

17 MR. MACDONNELL: Your Honor, there's one matter
18 and I apologize that I might have missed. In Claimant's
19 Exhibit 1, page 989 is an echo. I'm assuming that the
20 objection is just mainly to the blood test, but there
21 wouldn't be an objection to the echo of this man's heart.

22 MR. MATTINGLY: I thought there was a copy of
23 that some place else. That may be incorrect, but if there
24 is not an extra copy of that somewhere else, I would not
25 have an objection to that echocardiogram.

1 JUDGE HARRIS: It's just page nine ---

2 MR. MACDONNELL: 989, Your Honor.

3 JUDGE HARRIS: All right. Anything else?

4 MR. MACDONNELL: No, Your Honor.

5 JUDGE HARRIS: All right. So, I will allow
6 Claimant's 1, pages 1 through 402 and page 969 and now 989.
7 The remaining --- and what's the total?

8 (Whereupon, the documents marked
9 for identification as Claimant's
10 Exhibit 1 were admitted into
11 evidence.)

12 MR. KLAES: 1,040 pages, Your Honor.

13 JUDGE HARRIS: All right. The remaining pages
14 of Claimant's 1 are that part of the exhibit upon which I
15 reserve ruling and will advise parties of my ruling prior to
16 their submission of any closing argument in this matter
17 because that would be something the parties would need to
18 consider prior to making any closing argument in this case.
19 So, let's talk about schedule for that.

20 MR. MATTINGLY: And Judge, let me just ask for
21 clarification on that. I assume you'll rule on my objection
22 to my own exhibit, Exhibit 7 at that point?

23 JUDGE HARRIS: I'm ruling on that now. I'm
24 allowing Employer's Exhibit 7 in its entirety as the
25 Employer itself presented it in this proceeding and your

1 concerns about that part of Employer's 7 that was augmented
2 by Claimant are duly noted for the record. The medical
3 articles will be given their appropriate weight in this
4 matter and that is that with regard to Employer's 7. So,
5 the only reservation remains with regard to Claimant's 1 as
6 I've already described.

7 I certainly expect to rule on the outstanding
8 evidentiary issue as soon as possible. Looking at
9 submission of closing briefs by June 29th. Mr. MacDonnell,
10 does that work with your schedule?

11 MR. MACDONNELL: We have no objection, Your
12 Honor.

13 MR. MATTINGLY: That's more than generous.

14 JUDGE HARRIS: Is there anything further to
15 present, Mr. MacDonnell?

16 MR. MACDONNELL: Not from Claimant, Your Honor.

17 JUDGE HARRIS: Mr. Mattingly?

18 MR. MATTINGLY: Nothing from the Employer.

19 JUDGE HARRIS: Okay. All right, the record
20 shall reflect that I will be returning the exhibits that
21 were received in evidence to the parties for the parties to
22 transmit those exhibits to my office by whatever means the
23 parties choose, by mail, Express Mail or otherwise and the
24 record shall remain open until June 29, 2012 for submission
25 of written closing arguments in this matter. I expect to

1 rule on the outstanding evidentiary issue concerning
2 Claimant's Exhibit 1 in a reasonable time prior to the due
3 date for closing briefs. If there's nothing else, then this
4 hearing is adjourned. Off the record, please.

5 [Whereupon, the hearing was concluded at 10:10

6 a.m.]

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1 C E R T I F I C A T E

2

3 Case Name: Patricia F. Fitzwater

4 Case Number: 2010-BLA-05364

5 Date: April 17, 2012

6 Location: Beckley, West Virginia

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8 before the United States Department of Labor, Office of
9 Administrative Law Judges, were held according to the record
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**Issue Date: 03 April 2014**

Case No.: 2010-BLA-05364

In the Matter of

PATRICIA F. FITZWATER,
Widow of JACKIE L. FITZWATER
Claimant

v.

WESTMORELAND COAL COMPANY
Self-Insured Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances: Timothy MacDonnell, Esq.
For the Claimant

Paul E. Frampton, Esq.
For the Employer

Cheryl E. Carroll
For the Director, Office of Workers' Compensation Programs

Before: **LYSTRA A. HARRIS**
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from the claim of Patricia F. Fitzwater ("Claimant") against Westmoreland Coal Company ("Employer") for survivor's benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 (the "Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as “black lung,” is a disease of the lungs resulting from coal dust inhalation.

On February 16, 2010, this case was referred to the Office of Administrative Law Judges (“OALJ”) for a formal hearing. DX 38.¹ Subsequently, on December 12, 2011, it was assigned to me. I held a hearing in Beckley, West Virginia on April 17, 2011, at which time the parties had full opportunity to present evidence and argument. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:²

- 1) Whether the Miner suffered from pneumoconiosis;
- 2) Whether the Miner’s pneumoconiosis arose out of his coal mine employment;
- 3) Whether Miner’s death was due to pneumoconiosis; and
- 4) Whether the Employer is the responsible operator.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for survivor’s benefits on January 18, 2009. DX 2. The District Director issued a Proposed Decision and Order awarding benefits on December 14, 2009. DX 30. Thereafter, the Employer timely requested a formal hearing. DX 31.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant is the widow of Jackie L. Fitzwater (“the Miner”), a miner who died on September 24, 2008. DX 2. During his lifetime, the Miner held various positions such as general inside laborer, shuttle car operator, driller, and shooter. DX 7. He also applied for Federal black lung benefits. According to a Proposed Decision and Order dated December 10, 1982, the Miner was eligible to receive an award of benefits if he terminated his coal mine employment within one year of the final determination. *See also Fitzwater v. Westmoreland Coal Company*, Case No. 81-BLA-10,491 (ALJ March 23, 1982) (finding the Black Lung Disability Trust Fund liable for benefits). The Miner’s employment records, however, indicate that he last worked in coal mine employment in July 1994. DX 5, 6. There is no record evidence that the Miner was receiving benefits on his lifetime claim.

¹ The following abbreviations are used in this Decision: “DX” refers to Director’s Exhibits; “CX” refers to Claimant’s Exhibits; “EX” refers to Employer’s Exhibits; “T.” refers to the transcript of the April 17, 2011 hearing.

² The Employer withdrew its contestation of the Claimant’s status as an eligible survivor. T. at 6. The Employer agreed to at least 29 years of underground coal mine employment. *Id.* at 5. It did not agree to the employment with Lady H occurring 1986 to 1994, although the Employer asserted that Lady H is the responsible operator because it employed the Miner for those years. *Id.*; Employer’s Brief at 2-3. The Employer agreed that this claim meets the date requirements for the PPACA amendments to apply, but preserved its challenge to the amendments. *Id.* at 6.

B. Hearing Testimony

The daughter of the Miner and Claimant, Vanessa Pardue, testified at the hearing. Ms. Pardue stated that the Miner worked for about 38.5 years in coal mining, 10 years of which were underground. She recalled that he worked above ground as a car dropper and truck loader and that the Miner also worked inside the tippie. She recalled that the Miner would return home from his work "black from head to toe with coal dust," both when he worked underground and when he worked above ground. At times, the Miner worked six days per week and sometimes on Sundays, she stated. Ms. Pardue averred that the Miner's shifts were eight hours long. She testified that the Miner would only take one week of vacation each year. T. 26-28.

Ms. Pardue also testified that her father's breathing ability declined over time. She first noticed the Miner's breathing problems around 1974. The Miner had to slow down and rest often, she stated; he could no longer attend football games, mow the lawn, or clean his car due to his shortness of breath. She testified that the Miner used continuous supplemental oxygen. T. at 28-33.

Regarding the Miner's death, Ms. Pardue related that the family decided to stop Coumadin in order to prevent the Miner from bleeding to death. She recalled that the decision was a "catch 22" because the cessation of Coumadin brought on strokes. She testified that her mother did not remarry after her father's death. T. at 34-36.

Finally, Ms. Pardue related that the Miner saw Dr. Smith for 25 years or more, as frequently as two to three times per month towards the end of his life. On cross examination, she stated that her father underwent heart valve replacement surgery in 1998 and smoked cigarettes; she did not know how much he smoked each day or when he quit, although she recalled seeing her father smoke during this century. T. at 35-37.

C. Relevant Medical Evidence

In support of her affirmative case, the Claimant presented the following evidence: Dr. Lynn N. Smith's medical report and deposition testimony (CX 2, 3); Dr. William C. Houser's medical report and deposition testimony (CX 4, 5); an autopsy report by Dr. M. Beatriz Lopes (CX 8); hospitalization and treatment records from Dr. Smith's practice (CX 1) and from the University of Virginia Hospital (CX 6); and the Miner's death certificate (CX 7).

In support of its affirmative case, the Employer presented the following evidence: interpretations of a chest X-ray dated 01/22/1981 by Dr. Paul Francke, Jr. and Dr. N. LeRoy Lapp (EX 2); pulmonary function tests dated 10/24/1979 and 01/22/1981 (EX 2); arterial blood gas tests dated 10/24/1979 and 01/22/1981 (EX 2); Dr. David M. Rosenberg's medical report and deposition testimony (EX 3, 7); Dr. Kirk E. Hippensteel's medical report and deposition testimony (EX 4, 6); Dr. Everett F. Oesterling's autopsy report (DX 17); the interpretation of 09/04/2008 CT scan as "other medical evidence" pursuant to § 718.107 (DX 16); hospitalization and treatment records from the University of Virginia Hospital (DX 16); and the Miner's employment history with Westmoreland Coal Company (EX 5). To rebut the Claimant's case, the Employer presented Dr. Stephen T. Bush's autopsy report (EX 1).

These items will be discussed in greater detail below.

D. Entitlement

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718. Under these regulations, Claimant bears the burden of demonstrating each of the following elements by a preponderance of the evidence: (1) the miner suffered from pneumoconiosis; (2) the pneumoconiosis arose from coal mine employment; and (3) the miner's death was caused by pneumoconiosis. 20 C.F.R. §§ 718.202-718.203, 718.205; *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986) (en banc); *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986) (en banc). Failure to establish any one of these elements precludes entitlement to benefits. Under Part 718, a claimant must demonstrate each element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986) (en banc); *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (en banc). Moreover, as Miner last engaged in coal mine employment in the State of West Virginia, appellate jurisdiction of this matter lies with the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

On March 23, 2010, the President signed the "Patient Protection and Affordable Care Act of 2010" ("PPACA"), Pub. L. 111-148, 124 Stat. 119, into law. Among other things, § 1556 of the PPACA changed adjudication of claims under the Act by reviving the fifteen-year presumption at § 718.305 for certain claims. Under § 718.305, where a miner has fifteen years or more of employment at an underground coal mine (or the equivalent), and is totally disabled due to a respiratory impairment, there is a rebuttable presumption that the miner's death was due to pneumoconiosis. By its terms, § 1556 applies to claims filed after January 1, 2005, that were pending on or after the date of the PPACA's enactment.

Consequently, as amended by the PPACA, § 718.305 may apply. The parties have stipulated to at least 29 years of underground coal mine employment, based on an agreement that the mine at which the Miner worked was at an underground coal mine, presumably referring to the site of an underground mine. T. at 7-8. I will defer my findings on pneumoconiosis until after I have determined whether the Miner was totally disabled by a respiratory or pulmonary impairment.

1. Whether the Miner was Totally Disabled by a Respiratory or Pulmonary Impairment

The claimant bears the burden to establish that the Miner was totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability," shall not be considered in determining whether a miner is

totally disabled due to pneumoconiosis. § 718.204(a). *See also Beatty v. Danri Corp.*, 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

1) Pulmonary Function Tests

A claimant may establish a miner's total disability based upon pulmonary function tests. In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume (FEV₁) test and, in addition, produce a qualifying value in at least one of the following: the forced vital capacity (FVC) test; the maximum voluntary volume (MVV) test; or the ratio of the FEV₁ value divided by the FVC value that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV₁, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The record contains the following pulmonary function test results:

Date of Test/ Exh. No.	Physician	Height	FEV ₁	FVC	MVV	FEV ₁ /FVC ratio	Valid ?
10/24/1979 EX 2	Daniel	68.25 in.	3.03	3.92	120	77%	Unknown ³
01/22/1981 EX 2	Walker	68.5 in.	3.19	4.21	154	76%	Unknown ⁴

The Miner was born in April 1936, so he was forty-three years old at the time of the first test and forty-four years old at the time of the second test. The Miner's height was listed at 68.25 inches and 68.5 inches. Where varying heights are listed for pulmonary function tests, I must resolve the discrepancies. *Protopappas v. Dir.*, *OWCP*, 6 B.L.R. 1-221, 1-223 (1983). Based on the record before me, I find the Miner was at least 68.38 inches tall. This is the average of the recorded heights.

³ The record does not include the results of at least three trials and does not include information from which I can determine whether there was acceptable variation.

⁴ The record shows that at least three trials were performed, but does not include information from which I can determine whether there was acceptable variation between trials.

For a forty-three year old male who is 68.38 inches tall the qualifying FEV₁ value is 2.21, the qualifying FVC value is 2.76, and the qualifying MVV value is 88. For a forty-four year old male who is 68.38 inches tall the qualifying FEV₁ value is 2.19, the qualifying FVC value is 2.74, and the qualifying MVV value is 88.

Discussion

The pulmonary function tests of record did not result in a qualifying FEV₁ value. While the validity of the tests is in question, I find that there is no test showing qualifying values. Hence, the Claimant has not established the Miner's total disability by a preponderance of the pulmonary function test evidence.

2) Arterial Blood Gas Tests

A claimant may also establish a miner's total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide (PCO₂) and percentage of oxygen (PO₂), based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2,999 feet above sea level or below), and PCO₂ level, a qualifying value must be less than or equivalent to the PO₂ listed in the table.

The record contains the following arterial blood gas test results:

Date of Test/ Exh. No.	Physician	PCO ₂	PO ₂	PCO ₂ (post-exercise)	PO ₂ (post-exercise)	Altitude
10/24/1979 EX 2	Daniel	38	60	38	75	0-2,999 ft.
01/22/1981 EX 2	Walker	38	63	37	82	3,000-5,999 ft. ⁵

For a PCO₂ value of 38, at an altitude of 2,999 feet or less, the qualifying PO₂ value must be equal to or less than 62. For a PCO₂ value of 38, at an altitude of 3,000 feet to 5,999 feet, the qualifying PO₂ value must be equal to or less than 57. For a PCO₂ value of 37, at an altitude of 3,000 feet to 5,999 feet, the qualifying PO₂ value must be equal to or less than 58.

Discussion

The arterial blood gas tests of record do not qualify. Accordingly, I find that the Claimant has not established that the Miner was totally disabled by a preponderance of the arterial blood gas test evidence.

⁵ The altitude at which this test was conducted is not of record. However, the test record reflects the test was administered in Quinwood, West Virginia. The altitude of Quinwood is 3,000 to 5,999 feet. See <http://westvirginia.hometownlocator.com/wv/greenbrier/quinwood.cfm>. Per 29 C.F.R. § 18.201, I may take judicial notice of such adjudicative facts.

3) Cor Pulmonale

A claimant may demonstrate the miner's total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). I find that the record preponderantly demonstrates that the Miner suffered from cor pulmonale with right-sided congestive heart failure based on the hospitalization and treatment records diagnosing the condition and based on the well-reasoned opinions of the Miner's treating physician, Dr. Smith and of Dr. Houser.

First, treatment records from the Miner's treating physician diagnose right-sided congestive heart failure and cor pulmonale. CX 1 at 186, 263, 266. As I will discuss in greater detail below, Dr. Smith initially diagnosed right-sided congestive heart failure due to restrictive pericarditis in 2003 and 2004. CX 1 at 37, 43. However, it appears that his opinion progressed over time such that he later attributed the right-sided heart failure to the Miner's underlying lung disease. CX 1 at 186 (finding a "history of severe congestive heart failure due to a combination of pulmonary hypertension, pneumoconiosis, and cor pulmonale"); CX 1 at 266 (finding pulmonary hypertension, cor pulmonale, due to a combination of restrictive lung disease and valvular heart disease). At his deposition, Dr. Smith explained that the lung disease progressed while the Miner's cardiac problems were already addressed; consequently, he believed that the lung disease caused the worsening right-sided heart failure. CX 3 at 45.

Second, a discharge summary dated 07/12/2003 from the University of Virginia hospital diagnosed right-sided failure likely due to multiple etiologies including severe obstructive sleep apnea, COPD, and interstitial lung disease. DX 16. A 09/01/2008 consultation note and a 08/18/2006 discharge summary reported pulmonary hypertension. *Id.* Accordingly, I find that the records from the University of Virginia support Dr. Smith's opinion that the Miner suffered from right-sided heart failure with lung disease and pulmonary hypertension.

Third, Dr. Smith and Dr. Houser, physicians who offered medical opinions in this matter, each opined that the Miner suffered from cor pulmonale with right-sided congestive heart failure in their medical reports and their deposition testimony. According to Dr. Smith, the Miner suffered from underlying lung disease (including clinical pneumoconiosis and emphysema), which caused significant cor pulmonale. CX 2, 3. He asserted that the Miner had normal left-sided function at the time of his death and that his previous restrictive pericarditis had been addressed; thus, he attributed the right-sided failure to underlying lung disease. CX 3 at 45. Likewise, Dr. Houser diagnosed cor pulmonale based on the Miner's chronic hypoxemia and echocardiograms and autopsy indicating pulmonary hypertension. CX 4, 5. Below, I will find that Dr. Smith's opinion, as the Miner's treating physician, is due controlling weight in this matter and I will find that Dr. Houser's opinion is due full weight as a well-reasoned opinion based on a review of extensive documentation. I incorporate those findings here. I note that autopsy reports found evidence of pulmonary hypertensive changes and right ventricular dilatation and that the University of Virginia records also diagnose pulmonary hypertension. DX 15/CX 8; DX 17; DX 16.

The Employer's experts, Dr. Rosenberg and Dr. Hippensteel, also submitted opinions in this matter. Dr. Rosenberg diagnosed cor pulmonale of multifactorial etiology, unrelated to past

coal dust exposure. EX 3. He stated that diastolic dysfunction was a major factor and that aortic stenosis and obstructive sleep apnea contributed. *Id.* Dr. Hippensteel, on the other hand, opined that the Miner's other heart conditions caused the right-sided failure and the Miner did not have cor pulmonale. CX 6 at 11-18. Below, after summarizing their opinions in detail, I will find that Dr. Rosenberg's and Dr. Hippensteel's opinions are due little weight because they reviewed less extensive documentation upon which to base their determinations that the Miner's lung disease did not cause any impairment and did not cause the congestive heart failure. Overall, I find Dr. Houser's and Dr. Smith's opinions that the Miner had cor pulmonale with right-sided failure more persuasive. Dr. Smith and Dr. Houser each testified that the pericarditis was corrected by pericardial stripping surgery while the lung disease and the right-sided heart failure progressed.

Based on the foregoing, I find that the Claimant has put forward preponderant evidence of cor pulmonale with right-sided heart failure and has established the Miner's total disability through this method.

Physician Opinion

The final method of determining whether the Miner was totally disabled is through the reasoned medical judgment of a physician that the Miner's respiratory or pulmonary condition prevented him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the doctor bases the diagnosis. *Id.* An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. *Brigrance v. Peabody Coal Co.*, 23 B.L.R. 1-170 (2006) (en banc).

The record includes the following physician opinions:

Dr. Lynn Smith. CX 2/DX 18; CX 3.

Dr. Lynn Smith, the Miner's treating physician for over 20 years, wrote a letter dated December 31, 2008, in which he asserted that the Miner died of complications from his underlying lung diseases including clinical pneumoconiosis confirmed on autopsy. Specifically, Dr. Smith stated, "[a]s a result of this pneumoconiosis, he developed significant cor pulmonale and developed multiple small bowel AV malformations," which "resulted in chronic and persistent blood loss through his GI tract." According to Dr. Smith, the Miner received over 100 units of blood over several years, but his bleeding could not ultimately be controlled.

Dr. Smith further explained his opinion, qualifications, and relationship with the Miner at a deposition. CX 3. He stated that he is Board-certified in internal medicine and has treated coal miners as part of his practice since 1982. He was the Miner's primary care physician from 1983 to 2008, during which he treated the Miner for lung disease, valvular heart disease, diabetes, and

other conditions. In his treatment of the Miner, he ordered testing including X-rays, pulmonary function tests, and arterial blood gas tests. He stated that he saw the Miner about two to four times per year in the beginning and about once or twice a month toward the end, as the Miner's health declined. He noted that the Miner worked for 38.5 years in coal mine employment and smoked for most of his adult life, for an estimated total of 70 to 80 pack-years. *Id.* at 4-7, 15.

At the deposition, Dr. Smith reviewed the results of arterial blood gas tests and pulmonary function tests from the Miner's medical records and asserted that they show that he was totally disabled by a progressive pulmonary impairment during his lifetime. In particular, Dr. Smith noted the results of the following arterial blood gas tests: 03/26/1999 (revealing minimal hypercapnia still within normal limits); 01/04/2001⁶ (revealing increased hypercapnia, significant hypoxia even with oxygen supplementation, and significant deterioration from the prior test); 05/13/2002 (demonstrating evidence of chronic respiratory failure⁷ requiring oxygen supplementation); 01/26/2004 (showing hypercapnia and hypoxia requiring oxygen supplementation). Collectively, according to Dr. Smith, the tests show "a progression of his lung disease over a series of years, to where he developed worsening interstitial lung disease and emphysematous changes that resulted in both the presence of hypercapnia, as well as the presence of hypoxia." He opined that the Miner's valve replacement in 1998 probably did not affect the arterial blood gas results because the pressure gradients related to the valve were alleviated with surgery. Dr. Smith reviewed a 02/28/1999 pulmonary function test and a report by Dr. Richard Durham, a pulmonologist, and opined that they show that the Miner had progressive, chronic lung disease with obstruction and restriction. He testified that the Miner probably started using nighttime oxygen by 2000 or at least by 2003 or 2004 and that he was oxygen dependent by the end of his life due to his underlying lung and heart disease. He stated that the Miner was totally disabled from a pulmonary standpoint such that he could not have performed any employment. *Id.* at 8-16.

Dr. William C. Houser. CX 4, 5.

Dr. Houser is Board-certified in internal medicine and pulmonary disease. CX 5 at 4. He submitted a medical report dated February 15, 2012 containing his opinions based on a review of the Miner's medical records.⁸ CX 4. Dr. Houser included a list of medical authorities and attached the medical literature to which he cited. He recorded that the Miner worked about forty years of coal mine employment as a laborer, shuttle car operator, driller, shooter, utility man, and stationary and mobile equipment operator. Dr. Houser reported that the Miner smoked from between 30 to 80 pack-years, based on his records; he noted one estimation that the Miner smoked 1.5 packs per day for 40 years and continued to smoke at least a few cigarettes daily until 2007. Dr. Houser reviewed reports by Dr. Donald L. Rasmussen and Richard R. Durham, as well as test results. In Dr. Houser's opinion, the Miner suffered from a combination of

⁶ Dr. Smith testified that the Miner's cardiac surgery around the time of that test should not have affected the arterial blood gas measurements. CX 3 at 33-34.

⁷ On cross examination, Dr. Smith acknowledged that the Miner's blood gases at that time were affected by toxic shock syndrome and would not reflect his baseline pulmonary status. CX 3 at 32.

⁸ Dr. Houser listed the records he reviewed as follows: the Miner's death certificate; an autopsy final review report (DX 14); an autopsy final report (DX 15); UVA treatment records (DX 16); Dr. Oesterling's report (DX 17); Dr. Smith's letter (DX 18); Dr. Smith's treatment records; the Miner's employment history; and laboratory reports.

clinical and legal pneumoconiosis, which caused hypoxemia, pulmonary hypertension, and cor pulmonale.

On March 22, 2012, Dr. Houser testified at a deposition. CX 5. He stated that about 20% of his practice is related to the treatment of occupational lung disease, primarily black lung disease. Dr. Houser indicated that he has performed approximately 1000 or more black lung evaluations for the U.S. Department of Labor since 1979 and that he has treated several hundred coal miners in his practice. He stated that he reviewed additional records after he wrote his medical report.⁹ Dr. Houser concluded that the Miner was totally disabled from a pulmonary perspective based on his use of supplemental oxygen, including continuous oxygen for several years, and his chronic hypoxemia, with exercise-induced hypoxemia, and cor pulmonale. Dr. Houser reviewed the Miner's arterial blood gas studies from his files and asserted that they were abnormal. He diagnosed cor pulmonale based on the Miner's chronic hypoxemia and echocardiograms and autopsy demonstrating pulmonary hypertension. He also noted the Miner's pulse oximetry of 85. He testified that the Miner required oxygen due to his lung disease with coal workers' pneumoconiosis and emphysema. Dr. Houser did not believe the Miner's aortic stenosis affected his arterial blood gas studies or caused any significant change in pulmonary status; he believed the aortic stenosis was already treated with valve replacement surgery. *Id.* at 4-6, 10, 15-24, 38-39, 70-71.

Dr. David M. Rosenberg. EX 3, 7.

Dr. Rosenberg is Board-certified in internal medicine, pulmonary disease, and occupational medicine. He is also a certified B reader. Dr. Rosenberg reviewed medical records¹⁰ and submitted a report dated April 14, 2010. Dr. Rosenberg opined that the Miner had minimal clinical coal workers' pneumoconiosis, discernable only pathologically, and no associated pulmonary disability. He stated that the Miner's chest X-rays, pulmonary function tests, exercise arterial blood gas tests, and treatment records were not diagnostic of clinical coal workers' pneumoconiosis. According to Dr. Rosenberg, the Miner's pulmonary function tests did not reveal obstruction or restriction and the Miner demonstrated normal gas exchange during exercise; thus, he stated that the Miner did not have "associated disability" from a pulmonary perspective.

However, Dr. Rosenberg noted that, later in his life, the Miner became disabled due to various cardiac problems such as critical aortic stenosis with valve replacement and right-sided congestive heart failure in association with pulmonary hypertension. Dr. Rosenberg opined that the etiology of the Miner's right-sided congestive heart failure (cor pulmonale) was multifactorial, but unrelated to coal dust exposure. One major factor contributing to the pulmonary hypertension and right-sided heart failure, in his opinion, was diastolic dysfunction: "the stiff left ventricle associated with diastolic dysfunction causes a pressure backup which is

⁹ The records Dr. Houser listed include: Dr. Smith's deposition; medical reports by Dr. Hippensteel, Dr. Rosenberg, and Dr. Bush; X-ray interpretations of a film dated 01/22/1981; and pulmonary function test and arterial blood gas test results dated 10/24/1979 and 01/22/1981.

¹⁰ The records Dr. Rosenberg reviewed include the claim application; arterial blood gas tests dated 10/13/1978, 10/24/1979, 01/22/1981; pulmonary function tests dated 10/24/1979, 01/22/1981; interpretations of a 05/05/1981 chest X-ray; medical records from the University of Virginia; the Miner's death certificate; autopsy reports by Drs. Oosterling and Bush; and a medical report by Dr. Smith.

transferred to the right side of [the] heart.” As diastolic dysfunction causes right-sided heart failure, so too does aortic stenosis cause left ventricular diastolic dysfunction, which can also be “potentiated after aortic valve replacement.” These conditions, as well as constrictive pericarditis and inadequately treated obstruction sleep apnea, led to Miner’s right-sided heart failure, Dr. Rosenberg asserted.

On April 9, 2012, Dr. Rosenberg testified at a deposition. EX 7. He indicated that he reviewed additional information.¹¹ According to Dr. Rosenberg, the Miner had no obstruction, no restriction, normal gas exchange with exercise, minimal coal workers’ pneumoconiosis, and only minimal emphysema which would be insufficient to cause loss of the alveolar capillary bed. Dr. Rosenberg acknowledged that pathologists found emphysema on autopsy, but opined that emphysema has to affect about a third of the lungs before it causes significant impairment and the Miner’s emphysema was minimal. On cross examination, Dr. Rosenberg acknowledged that emphysema is a form of COPD and that COPD can be associated with pulmonary hypertension and can cause cor pulmonale. He maintained that there are other causes of cor pulmonale including sleep apnea and constrictive pericarditis. *Id.* at 25-27, 30-33, 39.

Dr. Kirk E. Hippensteel. EX 4, 6.

Dr. Hippensteel is Board-certified in internal medicine, pulmonary disease, and critical care medicine; he is also a certified B reader. Dr. Hippensteel reviewed medical records pertaining to the Miner and issued an opinion dated May 24, 2010.¹² Based on his review, Dr. Hippensteel concluded that the Miner had minimal simple clinical coal workers’ pneumoconiosis, based on his autopsy, which did not have any clinically significant effect on the Miner’s lung or heart function and did not contribute to his death. Similarly, Dr. Hippensteel opined that the Miner did not have an obstructive impairment during his lifetime to support the historical diagnoses of COPD in his medical records. Thus, he asserted that there was no clinical significance of the emphysema observed at autopsy, based on the “one discussion of his pulmonary function tests in these records.” He opined that chronic right pleural effusion was the cause for the restrictive impairment from which the Miner suffered.

Dr. Hippensteel also testified at a deposition on March 30, 2012. EX 6. He stated that he reviewed additional records, but did not review Dr. Smith’s treatment file (CX 1).¹³ Dr. Hippensteel reiterated that there were no specific pulmonary function tests late in the Miner’s life to suggest that the emphysema on autopsy produced a functional abnormality. He stated that a 1991 pulmonary function study revealed normal function. He opined that the Miner was prescribed supplemental oxygen for his heart disease. *Id.* at 8, 20-21, 41-42.

¹¹ Dr. Rosenberg stated that he also reviewed Dr. Smith’s deposition testimony, Dr. Houser’s medical report, and the Miner’s employment history from Westmoreland Coal Company. EX 7 at 39.

¹² The records Dr. Hippensteel reviewed include the following: the survivor’s claim for benefits; the results of a pulmonary function test dated 10/24/1979; interpretations of a 01/22/1981 chest X-ray; records from the University of Virginia Hospital from 1998 to 2008; the Miner’s death certificate; autopsy reports by Drs. Lopes, Oesterling, and Bush; and Dr. Smith’s 12/31/2008 letter.

¹³ In particular, Dr. Hippensteel related that he reviewed Claimant’s exhibits relating to Dr. Houser’s medical report and Dr. Smith’s deposition. EX 6 at 8.

He attributed the Miner's right-sided heart failure to heart disease rather than to lung disease. Specifically, Dr. Hippensteel asserted that the Miner underwent surgery for aortic valve replacement and then suffered from left-sided heart failure that created pleural effusions; he stated that the Miner had ongoing congestive heart failure after the surgery. Consequently, he stated,

[T]here is back pressure into the lungs related to that severe stenosis and that creates what we call pulmonary venous hypertension. And pulmonary venous hypertension is one of the significant causes for pulmonary arterial hypertension. So this man had a course of events related to his heart valve that were severe and created heart damage as was found on autopsy in both his left heart and right side of his heart and it wasn't damage to the right side of his heart that related to cor pulmonale or lung disease.

Additionally, Dr. Hippensteel opined that the Miner's sleep apnea, atrial fibrillation, and arterial venous malformations also related to or contributed to his heart trouble. Dr. Hippensteel believed that the Miner did not have cor pulmonale. On cross examination, Dr. Hippensteel agreed that emphysema, COPD, and coal workers' pneumoconiosis can cause cor pulmonale. *Id.* at 11-18, 23, 35.

Treatment Records.¹⁴ CX 1, 6; DX 16.

CX 1

The treatment records from Dr. Smith, submitted as CX 1, include office notes, discharge summaries, X-ray interpretations, laboratory results, and the reports from other objective medical tests from the 1980s to 2008. The records diagnose and discuss multiple medical conditions such as gastrointestinal bleeding, atrial fibrillation, valve replacement, toxic shock syndrome, restrictive pericarditis, pneumoconiosis, hypertension, acute renal failure, congestive heart failure, chronic obstructive pulmonary disease, diabetes, obstructive sleep apnea, and pulmonary hypertension. Generally, the Miner complained of shortness of breath on many occasions, used nebulizers, often displayed decreased breath sounds (especially on the right), and used supplemental oxygen at many times. He also underwent blood transfusions and regular blood tests to monitor his non-respiratory medical issues. I will not discuss the radiographic evidence from this exhibit in this section regarding total disability, as I have found that the reports do not discuss any effect of or impairment due to the conclusions reflected in such evidence.

As the treatment records which comprise CX 1 are voluminous, I will focus on reports and test results suggesting that the Miner suffered from a totally disabling respiratory or pulmonary impairment during his lifetime. For example, CX 1 contains the results of multiple oximetry and arterial blood gas tests. A 06/20/2005 oximetry test (with oxygen and CPAP) revealed fifteen desaturation events that were longer than three minutes in duration and fifty-seven desaturation events of less than three minutes duration; the longest time with a saturation less than 88 was 00:09:20. CX 1 at 9. In 2004, the Miner's arterial blood gases measured PCO₂

¹⁴ I will not here consider the Miner's death certificate as I find that it is not probative of whether the Miner suffered from a totally disabling respiratory or pulmonary impairment during his lifetime. CX 7.

51 and PO₂ 71.¹⁵ *Id.* at 30 (History and Physical 01/26/2004). A 01/04/2001 arterial blood gas test revealed PCO₂ 49, PO₂ 54¹⁶ and oxygen saturation 88.7 percent, while an office note of the same date recorded oxygen saturation in the 85 percent range. *Id.* at 135-36, 151.

A clinic note from Dr. Richard Durham dated 08/25/1999 recommended that the Miner use continuous at-home oxygen and reported that the Miner's oxygen saturation started at 89 percent and dropped to 86 percent on two liters of oxygen. *Id.* at 368-69. On August 31, 1999, the Miner's ambulatory oximetry was measured again demonstrating exercise-induced hypoxia with a drop from 95 percent to 85 percent. *Id.* at 370. On March 11, 1999, an arterial blood gas test showed PCO₂ 44, PO₂ 65.¹⁷ *Id.* at 964. On March 26, 1999, Dr. Durham examined the Miner recording an ambulatory oximetry drop from 92 percent to 85 percent with six minutes of walking and PCO₂ 44 and PO₂ 65. *Id.* at 379-80. A 02/09/1984 arterial blood gas test revealed PCO₂ 40.6, PO₂ 77.6.¹⁸ *Id.* at 401. On October 13, 1978, the Miner was evaluated by Dr. D. L. Rasmussen, who opined that he showed moderately impaired intrapulmonary oxygen transfer and significant hypoxia with abnormal response to exercise. *Id.* at 396.

The records also include references to pulmonary function tests interpreted as demonstrating impairment and corroborate the Miner's use of supplemental oxygen. A history and physical report by Dr. Richard Durham asserted that the Miner's pulmonary function test showed a combined obstructive and restrictive process of moderate severity. *Id.* at 379-80. Pre- and post-bronchodilator tests dated 02/28/1991 suggested early small airways obstruction; an office note of the same date opined that the Miner's respiratory ability was declining: "PFT's do indeed show evidence of decrease by about 10 percent. PO₂ is down to 67. Forced vital capacity has dropped by 10 percent as well. All of his overall pulmonary functions are decreased by 10 percent since 1984." *Id.* at 386, 393. In June 2006, it was recommended that the Miner wear oxygen on a regular basis. *Id.* at 191. Indeed, as early as August 1999 the Miner was instructed to use continuous at home oxygen. *Id.* at 368-369.

A review of these treatment records supports finding that the Miner suffered from congestive heart failure, and particularly right-sided congestive heart failure, over many years. The Miner also experienced restrictive pericarditis, left-sided heart failure, pulmonary hypertension, and cor pulmonale. *Id.* at 36-37, 40, 43, 186, 263, 266.

DX 16/CX 6

DX 16/CX 6 contains records from the Miner's hospitalizations at the University of Virginia over 10 years. He was treated for bleeding from arteriovenous malformations (AVMs), stroke, renal disease, congestive heart failure, atrial fibrillation, pulmonary hypertension, pericardial constriction, among other conditions. DX 16 includes multiple X-ray interpretations, ultrasound interpretations, and a CT scan. I will not discuss the radiographic evidence in this section regarding total disability, as I have found that the reports do not discuss any effect of or impairment due to the findings of the tests. Most documents included in this exhibit report an 80

¹⁵ I note that these results would qualify for disability under the regulations.

¹⁶ I note that these results would qualify for disability under the regulations.

¹⁷ I note that these results would not qualify for disability under the regulations.

¹⁸ I note that these results would not qualify for disability under the regulations.

pack-year history of smoking. DX 16 (08/24/2008 Discharge Summary; 09/22/2008 Consult Note; 09/01/2008 Consult Note; 05/30/2002 Discharge Summary; 12/24/2000 Discharge Summary). There is some variation in the hospitalization records regarding when the Miner quit smoking. A 09/01/2008 Consult Summary states that he quit in 2007. Because the 2008 report is the most recent, I find this estimation more credible than earlier reports which state that the Miner quit smoking before 2007.

The Miner was hospitalized in August and September 2008 before his death. A 09/24/2008 discharge/death summary described the Miner's conditions at the time of his death: GI bleeding from intestinal AVMs; chronic renal failure with progression to end-stage renal disease; cirrhosis secondary to congestive heart failure; spontaneous bacterial peritonitis; and infective endocarditis. The report noted how the Miner's anticoagulation increased his bleeding from the intestinal AVMs. The Miner was described as transfusion dependent at the time of his death. His family chose to stop anticoagulation hoping to slow his bleeding. He was discharged to comfort care. A 09/01/2008 consult note reported the Miner's past medical history: 1) congestive heart failure with diastolic heart failure; 2) aortic stenosis, status post aortic valve replacement December 1998; 3) sleep apnea treated with CPAP; 4) type 2 diabetes; 5) hypertension; 6) chronic atrial fibrillation; 7) chronic kidney disease; 8) chronic GI bleeding secondary to AVMs; 9) coal workers' pneumoconiosis; 10) tachybrady syndrome status post pacemaker; 11) status post pericardiectomy in 2000 due to constrictive pericarditis; 12) endocarditis of mechanical valve; 13) MCA stroke; 14) recent SBP [spontaneous bacterial peritonitis]. The report also noted pulmonary hypertension.

According to a 08/24/2008 Discharge Summary, the Miner suffered a stroke on August 9, 2008 thought to be due to atrial fibrillation. The same report noted a 08/02/2008 echocardiogram revealing normal left ventricular systolic function, mild left concentric ventricular hypertrophy, mildly dilated left ventricular chamber, and mild mitral regurgitation. On August 19, 2008, the Miner's systolic function was found to be within normal limits. The 08/24/2008 Discharge Summary also reported that the Miner was using supplemental oxygen, experiencing right pleural effusion (thought to be due to congestive heart failure), and failing to wear his CPAP at night.

The Miner was also hospitalized in August 2006. A Discharge Summary dated 08/18/2006 diagnosed congestive heart failure exacerbation and pulmonary hypertension. The report stated that the Miner had difficulty wearing his CPAP over the last six months. It noted a history of coal workers' pneumoconiosis and reported that the Miner was using three liters of supplemental oxygen. An X-ray showed pleural effusion and pulmonary fluid overload. An echocardiogram showed normal left ventricular systolic function and mild concentric left ventricular hypertrophy. The report asserted that the refractory congestive heart failure was thought to be due to pulmonary hypertension due to multiple causes including pneumoconiosis, left ventricular hypertrophy, and obstructive sleep apnea; the physicians opined that there was no evidence of recurrent pericardial constriction.

Prior to 2006, the Miner was also hospitalized at the following times:

February 2004: congestive heart failure with no evidence of a constrictive disease, history of COPD, "PFTs . . . confirmed more of a restrictive process," continued on nebulizers (02/26/2004 Discharge Summary);

July 2003: congestive heart failure, chronic decreased exercise tolerance, "[w]e felt that his right-sided failure was probably due to multiple etiologies including severe obstructive sleep apnea, COPD, interstitial lung disease as the patient has a history of black lung," no evidence of recurring constrictive pericarditis (07/12/2003 Discharge Summary);

May 2002: toxic shock syndrome, renal failure, gastrointestinal bleed, left lower extremity cellulitis, atrial fibrillation, left ventricle function normal, cardiomegaly on X-ray (05/30/2002 Discharge Summary);

December 2000: constrictive pericarditis, congestive heart failure from restrictive pericardial thickening (12/24/2000 Discharge Summary, 12/26/2000 Outpatient Encounter Note);

October 1999: cardiac catheterization, no evidence of pulmonary hypertension (10/21/1999 Discharge Summary); and

December 1998: aortic valve replacement with mechanical valve (12/05/1998 Discharge Summary).

Discussion

Initially, I note the qualifications of the physicians who offered opinions. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Each physician is Board-certified in internal medicine; Drs. Houser, Hippensteel, and Rosenberg are also Board-certified pulmonologists while Dr. Smith is not so certified. Because Dr. Smith was the Miner's treating physician and gained first-hand knowledge of the Miner's condition based on examinations over a course of 25 years, I will not detract any weight from his opinion based on his credentials. I note that Dr. Smith testified that he has treated coal miners for respiratory conditions since 1982. Thus, I find that each physician is well-qualified and I will afford equal weight to their opinions with respect to their qualifications.

At 20 C.F.R. § 718.104(d), the regulations set forth specific considerations in weighing a treating physician's opinion, requiring the Administrative Law Judge to give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the ALJ must take into consideration the following factors in weighing the opinion of the miner's treating physician:

- (1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;
- (2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;
- (3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition;
- (4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition;
- (5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

Thus, in my consideration of treating physicians' opinions, I must consider the above factors. I note that the Department has stated the following regarding the "treating physician" rule:

The rule does not require the adjudicator to defer to [the physician's] conclusions regardless of the other evidence in the record. The adjudicator must have the latitude to determine which, among the conflicting opinions, presents the most comprehensive and credible assessment of the miner's pulmonary health. For the same reasons, the Department does not consider subsection (d) to be an evidentiary presumption which shifts the burden of production or persuasion to the party opposing entitlement upon the submission of an opinion from the miner's treating physician. Accordingly, the Department declines to eliminate the requirement in subsection (d)(5) that a treating physician's opinion must be considered in light of all relevant evidence in the record.

65 Fed. Reg. 79,334 (Dec. 20, 2000).

In this case, Dr. Smith treated the Miner for respiratory or pulmonary conditions, including COPD, cor pulmonale, and chronic hypoxemia, for a significant length of time (i.e., 25 years). He ordered and reviewed many objective tests in the course of his treatment, such as X-rays, pulmonary function tests, and arterial blood gas tests, and he saw the Miner two to four

times per year in the beginning and as frequently as once or twice a month toward the end. At his deposition, Dr. Smith referred to specific facts and test results to support his opinion that the Miner was totally disabled during his lifetime. He pointed to numerous arterial blood gas test results, a pulmonary function test, and pulmonologist Dr. Richard Durham's opinion to support this conclusion. In particular, I note that Dr. Smith was able to assess the Miner's need for supplemental oxygen over time based on his presentation and his arterial blood gases and oximetry results. His treatment record for the Miner consists of over 1,000 pages of medical records which suggest his thorough understanding of the progression of the Miner's health and abilities over time and the conditions which led to his death. Dr. Smith's opinion is consistent with the information in CX 1 and DX 16, which confirms the Miner's use of supplemental oxygen, his hypoxia based on ambulatory oximetry tests, and his worsening lung function and right-sided heart failure. Based on this information, I find that Dr. Smith has obtained superior and relevant information concerning the Miner's condition and I afford controlling weight to his well-reasoned opinion.

I afford full weight to Dr. Houser's opinion that the Miner was totally disabled by a pulmonary or respiratory impairment. Dr. Houser reviewed extensive medical records, including Dr. Smith's treatment records. He concluded that the Miner was totally disabled from a pulmonary perspective based on his use of supplemental oxygen, including continuous oxygen for several years, chronic hypoxemia with exercise-induced hypoxemia, and cor pulmonale. He considered the results of arterial blood gas studies, pulse oximetry studies, echocardiograms, and the Miner's autopsy. Overall, I find that Dr. Houser offered a well-reasoned opinion based on objective medical test results and afford his opinion full weight.

I afford less weight to the opinions of Drs. Rosenberg and Hippensteel as neither physician reviewed Dr. Smith's treatment records. Accordingly, I find that they each based their opinion on less extensive documentation and did not have the benefit of reviewing many tests and treatment notes which substantiated the opinions of Drs. Smith and Houser that the Miner was totally disabled. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be given to an opinion supported by more extensive documentation over an opinion supported by limited medical data).

Furthermore, I find that the hospitalization and treatment records support a finding of total disability. The records confirm that the Miner was on continuous supplemental oxygen for two or more years before his death. They show that he suffered from hypoxia based on the results of multiple tests recorded over multiple years as interpreted by Dr. Smith and Dr. Houser. Additionally, Dr. Smith's records include opinions from two other physicians, Dr. Durham and Dr. Rasmussen, suggesting that the Miner suffered from a pulmonary or respiratory impairment based on their examinations.

I have assigned controlling weight to Dr. Smith's opinion that the Miner was totally disabled by a pulmonary impairment during his lifetime. I have also afforded full weight to Dr. Houser's similar opinion that the Miner was totally disabled and found that the treatment records support the opinions of Drs. Smith and Houser. I have given less weight to the opinions of Drs. Rosenberg and Hippensteel based on their review of less extensive medical documentation.

Overall, I find that the Claimant has put forward preponderant physician opinion evidence of the Miner's total disability.

Above, I found that the Claimant put forward preponderant evidence of cor pulmonale, but did not put forward preponderant pulmonary function or arterial blood gas test evidence of total disability. Based on all of the foregoing, I find that the Claimant has presented preponderant evidence of total disability based on the physician opinions (considering medical evidence through the Miner's death) and the evidence of cor pulmonale (based on diagnoses considering medical evidence through the Miner's death). I find that the outdated arterial blood gas tests and pulmonary function tests are outweighed by the more recent and comprehensive evidence of record demonstrating that the Miner was totally disabled.

Because the Claimant has established the Miner's total disability, she is entitled to the § 718.305 rebuttable presumption of death due to pneumoconiosis. Therefore, the burden now shifts to the Employer to rebut the presumption. *Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 939 (4th Cir. 1980); *Bosco v. Twin Pines Coal Co.*, 892 F.2d 1473 (10th Cir. 1989); *Mitchell v. Director, OWCP*, 25 F.3d 500, 506 (7th Cir. 1994).¹⁹ Once invoked, the burden shifts to the party opposing entitlement to demonstrate by a preponderance of the evidence either: (1) the miner's death did not arise out of coal mine employment; or (2) the miner suffered from neither clinical nor legal pneumoconiosis. If the party opposing entitlement meets this burden, then the presumptions are rebutted, and Claimant is not entitled to benefits. On the other hand, if the burden is not met, then Claimant is awarded benefits. The Board holds that standards for rebuttal under 20 C.F.R. § 718.305(d) are similar to the rebuttal standards at 20 C.F.R. § 727.203(b). *DeFore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). Where the burden is on the employer to disprove a presumption, the employer must "rule-out" coal mine employment as a cause of the death or disability. *Big Branch Resources, Inc. v. Ogle*, 737 F.3d 1063 (6th Cir. 2013).

2. Employer's Rebuttal

The Act defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." § 718.201(a). Pneumoconiosis is further divided into clinical and legal. Clinical pneumoconiosis consists of those diseases recognized by the medical community as having been caused by the presence of dust deposits in the lungs. § 718.201(a)(1). Legal pneumoconiosis, on the other hand, is any chronic lung disease or impairment that arises from coal mine employment. § 718.201(a)(2). The Employer must show that the Miner suffered from neither clinical nor legal pneumoconiosis or rule out coal mine employment as a cause of the Miner's death to rebut the presumption. While the Employer stated in its brief that the Miner did have simple pneumoconiosis, I will nonetheless consider all evidence because the Employer indicated

¹⁹ In proposed regulations published on March 30, 2012, the Department discussed the rebuttable presumption, and the employer's burden to rebut the presumption in detail. See Regulations Implementing the Byrd Amendments to the Black Lung Benefits Act: Determining Coal Miners' and Survivors' Entitlement to Benefits, 77 Fed. Reg. 19456, 19462-64 (Mar. 30, 2012). The Department's proposed regulations are consistent with the standards set out in this section of the Decision.

that it contested the issue of pneumoconiosis during the hearing. Employer's Brief at 3; T. at 5-6.

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

1. X-ray evidence. § 718.202(a)(1).
2. Biopsy or autopsy evidence. § 718.202(a)(2).
3. Regulatory presumptions. § 718.202(a)(3).²⁰
4. Physicians' opinions based upon objective medical evidence. § 718.202(a)(4).

a. X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102, using the classification system of the International Labor Organization (ILO), may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, does not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex. No.	Physician ²¹	Radiological Credentials ²²	Interpretation
01/22/1981	04/30/1981	EX 2	Francke	BCR B reader	ILO: Film completely negative
01/22/1981	11/27/1981	EX 2	Lapp	B reader	ILO: 0/0 small opacities rounded; 0/1, t, small opacities irregular, lower zones

Where two or more X-ray reports conflict, consideration shall be given to the radiological credentials of the physicians interpreting the X-rays. § 718.202(a)(1). It is well-established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder.

²⁰ A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304 or 718.305. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. I find there is no evidence of complicated pneumoconiosis, and so § 718.304 is inapplicable. Above, I determined that Claimant is entitled to the rebuttable presumption at § 718.305. When it implemented the PPACA's amendments to the Act ("the Byrd Amendments") in 2013, the Department of Labor withdrew § 718.306, which applied in cases of deceased miners who died before March 1, 1978, based on a determination that few, if any, such claims remained in litigation. *See* 77 Fed. Reg. 19,464 (Mar. 30, 2012) (proposed change); 78 Fed. Reg. 59,114, 59,115 (Sept. 25, 2013) (implementation).

²¹ Unless otherwise noted, professional credentials are found in the same exhibit as the physician's interpretation.

²² A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. *See generally*: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. *See* 42 C.F.R. § 37.51 for a general description of the B reader program.

Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 1-34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984).

For the purpose of analyzing the X-ray evidence, I give the most weight to the opinions of dually-qualified physicians (Board-certified radiologists and B readers). I give the most weight to the opinions of these physicians because they have wide professional training in all aspects of X-ray interpretation and have a certified proficiency in interpreting X-rays for indicia of pneumoconiosis. Unless there is a reason, as discerned in the record, to give greater or lesser weight to a specific X-ray interpretation, I give equal weight to the opinions of all physicians who possess the same level of professional credentials (e.g., B readers; dually-qualified physicians). Where there is one or more interpretation of a specific X-ray by a dually-qualified reader, I give minimal weight to the interpretations of readers with lesser radiological credentials.

I find no reason to afford greater or lesser weight to any specific interpretation, so I will rely on the professional qualifications of the physicians. The record includes two negative interpretations of an X-ray dated 01/22/1981. Dr. Francke, a dually-qualified physician, interpreted the film as completely negative and Dr. Lapp, a B reader, interpreted the film as negative for pneumoconiosis, category 0/0 and 0/1. Thus, I find that the X-ray evidence is negative for clinical pneumoconiosis. Negative interpretations, however, are not dispositive proof that the Miner did not suffer from pneumoconiosis. Likewise, the absence of X-ray interpretations indicating clinical pneumoconiosis is not dispositive proof that coal mine disease did not cause the Miner's death. Accordingly, I find that the Employer is unable to rebut the presumption at § 718.305 based solely on X-ray evidence.

b. Biopsy or Autopsy Evidence

Pursuant to 20 C.F.R. § 718.202(a)(2), "[a] biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis." § 718.202(a)(2). The regulations further provide, in part, the following: "A finding in an autopsy or biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis." § 718.202(a)(2). On the other hand, the provisions at § 718.106(c) state that a "negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on the biopsy, the results will constitute evidence of the presence of pneumoconiosis." § 718.106(c).

The regulations at § 718.201(a)(1) include anthracosis, anthracosilicosis, and anthrosilicosis within the definition of clinical pneumoconiosis. See *Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-104, 1-114 (2001). However, the regulations require that any disease that satisfies the definition of clinical pneumoconiosis be "characterized by permanent deposition of

substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment.” § 718.201(a)(1).

The record contains the following autopsy opinions:

Dr. M. Beatriz Lopes. DX 15/CX 8.

Dr. Lopes, the autopsy prosector, diagnosed the following:

Simple coal workers' pneumoconiosis

- Diffuse pulmonary emphysema
- Anthracotic nodules
- Mild pulmonary hypertensive changes

Cardiomegaly with ischemic cardiomyopathy

- Bilateral dilatation
- Right ventricular dilatation
- Left ventricular hypertrophy
- Multifocal subacute and remote infarcts (microscopic)

Atherosclerosis

- Aorta: Grade VII/VII
- Coronary arteries: 40% max occlusion with calcification

Status post aortic valve replacement and pacer placement

- Left chronic fibrotic pleuritis and chronic fibrotic pericarditis

In the gross examination, serous fluid was noted in the left and right pleural cavities and the pleura of both lungs were found to be adhered to the chest wall. The gross description of the cardiovascular system noted epicardial and pericardial surfaces adhered. The left ventricular wall measured 2.1 cm while the right ventricular wall measured 0.9 cm. The left and right atria and the right ventricle appeared dilated. The aorta showed severe atherosclerosis. The gross examination of the respiratory system showed a fibrous pleural surface adhered to the chest wall. “Cut sections reveal red-brown parenchyma which is remarkable for diffuse emphysema.”

Microscopically, the prosector observed diffuse emphysematous changes in sections of the lungs and “multifocal areas of anthracotic nodules.” There were mild pulmonary hypertensive vascular changes and pleural anthracosis and pleural thickening in the left lower lobe. The microscopic examination of the heart showed the following: evidence of ischemic cardiomyopathy; multiple microscopic areas of subacute infarction with macrophages in the left ventricle; multiple microscopic areas of remote infarction in the left and right ventricle; and moderate (40%) atherosclerosis in the LAD artery with calcification.

Overall, the autopsy prosector asserted that there were gross and histologic findings of simple coal workers' pneumoconiosis with dust macules and focal emphysema. “In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules.” According to the prosector, “[o]ther findings in this case include areas of subacute and chronic myocardial infarction. The decedent's coronary arteries had moderate atherosclerosis, but given his history of repeated GI bleeds, he was prone to bouts of hypotension, which could be

responsible for his myocardial ischemia. The decedent also had biatrial and right ventricular dilatation, but this is explained by the histologic findings of diffuse emphysema and pulmonary hypertension.”

Dr. Everett F. Oesterling. DX 17.

Dr. Oesterling, Board-certified in anatomical and clinical pathology, as well as nuclear medicine, reviewed histologic sections from the Miner's autopsy. He wrote a report dated July 28, 2009, detailing his findings. Dr. Oesterling reviewed the sections and found only minimal amounts of coal dust. He saw no gross evidence of black pigment. Microscopically, he noted the presence of occasional bright white silicate crystals and rare smaller less birefringent silica crystals of coal dust origin in one section showing anthracotic pigmentation of the pleural surface with “no true macular disease.” He found minimal enlargement of the air sacs and minimal enlargement of several air spaces and some cellular material within the air sacs. He disagreed with the prosector that there were nodules within the lung. He acknowledged the presence of coal dust concentrated within an intrapulmonary lymph node, but considered it a relatively modest quantity of dust and determined that it did not represent a nodule of coal workers' pneumoconiosis.

According to Dr. Oesterling, the interstitium appeared slightly thickened in slide seven and there were clusters of cells within the air sacs. He opined that they cells represented an infectious process and that there was an area of bacterial growth and chronic interstitial lymphoid pneumonitis. Due to the absence of crystalline material visible after applying partial polarized light, he concluded that “these black structures are indeed microbes and not coal dust.” Additionally, Dr. Oesterling opined that the lower lobe showed atelectasis and diffuse chronic and acute pneumonitis.

The presence of hemosiderin released into the air spaces suggested chronic passive congestion. Dr. Oesterling noted that the interstitium of the lung showed fibrosis and marked chronic inflammation. He observed “in the lower pole the black pigment which with polarized light . . . does show crystalline material” and concluded that it represented “very minimal anthracotic cuffing of the vascular structures.” He concluded that the Miner

experienced a very mild anthracotic pigmentation within the pleural surface with perivascular and peribronchial cuffing with anthracotic pigment. None of these achieve a size that warrants a diagnosis of macular coalworkers' pneumoconiosis and clearly there is no evidence of nodular change except for the interstitial lymph node which does not constitute coalworkers' pneumoconiosis.

He opined that the dust deposition would not alter pulmonary function, produce respiratory symptomatology, or have hastened, contributed to, or caused the Miner's death. Dr. Oesterling stated that the Miner “was experiencing pulmonary hypertension and indeed this could be due to his minor emphysematous change although it is not related to coal dust. It would also be the case if this gentleman was experiencing progressive heart failure which indeed the slides also suggested.” According to Dr. Oesterling, cardiac disease produced most of the changes within the lung tissue and concluded that the Miner had “ongoing ischemic myocardopathy with both

acute and more remote areas of myocardial infarction which are microscopic.” He asserted that the Miner had diffuse pericardial fibrosis, which would have impeded heart function.

Dr. Stephen T. Bush. EX 1.

Dr. Bush, Board-certified in anatomic and clinical pathology with a special competence in medical microbiology, wrote an autopsy report dated August 27, 2009 after reviewing the prosector’s report, the death certificate, the Survivor’s Claim for Benefits, and eight histologic slides. He opined that the Miner’s lungs showed a minimal degree of simple coal workers’ pneumoconiosis. He noted black dust pigment and rare birefringent particles of silicates and even more rare particles of silica in the pleura and the normal fibrous tissue adjacent to some small blood vessels and airways. According to Dr. Bush, “[r]arely is there evidence of a fibrous reaction associated with the dust pigment.” Additionally, he noted a lymph node with a small quantity of dust pigment. In his opinion, “[t]he limited amount of mineral particles in the lung parenchyma and the very limited extent of fibrosis justify the diagnosis of a minimal degree of simple coal workers’ pneumoconiosis.” He opined that the simple pneumoconiosis did not contribute to respiratory impairment or to the Miner’s death because the extent and degree of the disease was too limited.

In addition to simple pneumoconiosis, Dr. Bush observed a mild degree of generalized pulmonary emphysema with no relationship to the limited dust pigment. Dr. Bush opined that the “mild emphysema . . . may have caused some degree of respiratory impairment prior to death.” He stated that “most alveoli contain at least a few sloughed macrophages, some containing brownish iron pigment with localized areas of pulmonary edema and vascular congestion,” consistent with congestive heart failure. Finally, he noted areas of parenchyma collapse and infiltrating lymphocytes and macrophages with chronic atelectasis, the result of a focus of lung injury in the past, unrelated to coal dust pigment, according to Dr. Bush.

Dr. Bush opined that the Miner was totally disabled prior to his death as a result of blood loss, septicemia, renal failure, and possibly infected aortic valve prosthesis. He stated that sections of the heart revealed recent myocardial infarction “suggesting the infarct occurred some weeks before death.”

Discussion

Dr. Bush and Dr. Lopes diagnosed simple coal workers’ pneumoconiosis and emphysema. Dr. Oesterling did not diagnose simple coal workers’ pneumoconiosis and opined that the mild emphysematous change was not related to coal dust. I note that Dr. Oesterling and Dr. Bush are both Board-certified in pathology. While Dr. Lopes’ credentials are not of record, Dr. Lopes was the autopsy prosector. I find no reason to afford greater or lesser weight to any opinion because Dr. Lopes had the advantage of the prosector’s perspective while Dr. Oesterling and Dr. Bush are highly-qualified to render an opinion based on a review of slides.

Reviewing the autopsy opinions together, I find that they establish that the Miner suffered from simple clinical coal workers’ pneumoconiosis based on Dr. Lopes’ and Dr. Bush’s opinions which outweigh Dr. Oesterling’s contrary opinion. Thus, I find that the autopsy evidence does

not aid the Employer in rebutting the presumption by disproving the presence of clinical pneumoconiosis. I also find that the autopsy evidence neither establishes nor refutes the presence of legal pneumoconiosis. Each physician noted the presence of emphysema. Dr. Oesterling and Dr. Bush stated that it was not related to coal dust while Dr. Lopes appears to have linked the coal workers' pneumoconiosis diagnosis to the presence of emphysema. Even if I were to credit Dr. Bush's and Dr. Oesterling's statements that the emphysema was not due to coal mine dust exposure, it would still not aid the Employer because clinical pneumoconiosis has been established. Finally, I find that the autopsy opinions do not rule out coal mine employment as a cause of the Miner's death. Specifically, I find that those opinions confirm the presence of simple coal workers' pneumoconiosis, emphysema, and complex cardiac problems, as well as pulmonary hypertension and do not adequately rule out the coal dust as a factor in the complex presentation on autopsy. I find that the pathologists did not have the benefit of considering a complete picture of the Miner's hospital course and, therefore, I give little weight to the opinions of Drs. Bush and Oesterling that coal mine dust exposure did not contribute to the Miner's death.

c. Physicians' Opinions

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

An opinion is well-documented and reasoned when it is based on evidence such as physical examinations, symptoms, and other adequate data that support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). A medical opinion is adequately documented if it is based on items such as a physical examination and an accurate smoking history and report of coal mine employment. *See Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). An undocumented or unreasoned medical opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989); *see also Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how the underlying documentation supports his or her diagnosis).

Dr. Lynn Smith. CX 2, 3.

Based on his treatment of the Miner for 25 years and his review of the Miner's autopsy report, Dr. Smith opined that the Miner suffered from COPD with associated emphysema and interstitial lung disease related to his clinical pneumoconiosis and his cigarette smoking. He attributed the clinical pneumoconiosis to coal mine dust exposure and the emphysema predominantly to cigarette smoking, but also to occupational exposure. Dr. Smith also noted that

the Miner had sleep apnea which contributed to his underlying lung and heart disease. To support his diagnoses, he referenced a June 1987 X-ray showing hyperinflation and the Miner's autopsy revealing simple coal workers' pneumoconiosis, diffuse pulmonary emphysema, pulmonary hypertensive changes, cardiomegaly with evidence of an ischemic cardiomyopathy with atrial dilatation, evidence of left ventricular hypertrophy, a degree of vascular disease, chronic fibrotic pleural changes, and pericardial changes.

Based on the Miner's arterial blood gases throughout the years, Dr. Smith found that the Miner suffered from a progression of his lung disease, with worsening interstitial lung disease and emphysematous changes that resulted in hypercapnia and hypoxia such that the Miner required continuous supplemental oxygen by the end of his life. On cross examination, Dr. Smith explained that he originally diagnosed black lung in the medical records based on the Miner's stated history and that he did not independently evaluate the Miner for the presence of black lung disease. CX 2; CX 3 at 8-16, 40-41, 50-51.

In Dr. Smith's opinion, both smoking and coal mine dust exposure were significant contributing factors to the Miner's lung disease. He stated that he could not apportion the amount of impairment due to cigarette smoking versus coal mine dust exposure, but considered the Miner's over thirty-eight years of coal mine employment significant and noted that pneumoconiosis is a progressive disease. Regarding the cause of death, he asserted that the Miner died of complications from his underlying lung disease (including clinical pneumoconiosis and emphysema), which caused significant cor pulmonale and resulted in blood loss from multiple small bowel AV malformations; he considered the lung disease "a direct contributing factor." Dr. Smith opined that the Miner experienced an increase in venous pressure due to "a combination of his ongoing medical problems, which would have been his valvular heart disease, his sleep apnea, as well as his lung disease."²³ According to Dr. Smith, increased venous pressure is believed to cause the multiple small bowel and colonic vascular lesions which, in the Miner's case, caused longstanding GI bleeding, hastened by his use of anticoagulation medications (necessary because of the mechanical valve).²⁴

In sum, Dr. Smith opined that the anti-coagulation drugs caused the Miner to bleed more profusely from the AVMs (developed due to chronic right-sided failure), but the cessation of the anti-coagulations drugs resulted in a stroke. He disagreed with Dr. Oesterling's conclusions about heart disease and noted that the Miner had normal left-sided function at the time of his death. On cross examination, Dr. Smith agreed that restrictive pericarditis can cause cor pulmonale. He did not attribute the Miner's cor pulmonale to his cardiac problems, however, because Dr. Smith found that the cardiac problems had been addressed and treated yet the Miner showed progression of the right-sided heart failure; thus, he concluded that "it's very difficult from a clinical standpoint, since you've corrected those issues, to attribute his ongoing progressive disease to those processes." Dr. Smith opined that the Miner's "pulmonary disease was probably present before the aortic stenosis." CX 2; CX 3 at 15-18, 20-26, 45, 54.

²³ Dr. Smith later stated that he believed the Miner's valvular heart disease was stable after the valve replacement and that his sleep apnea was stabilized through the use of CPAP and oxygen supplementation. CX 3 at 18-19. Conversely, he testified that the Miner's lung disease progressively worsened over time. *Id.* at 18-19.

²⁴ Dr. Smith also stated that aortic stenosis can cause AV malformations. CX 3 at 52.

Dr. William Houser. CX 4, 5.

After his review of the medical records, Dr. Houser opined that the Miner suffered from clinical pneumoconiosis, based on his history of coal mine employment and pathology findings. He also diagnosed legal pneumoconiosis as emphysema due to the additive effect of cigarette smoking and coal dust exposure based on the autopsy findings. He wrote that the combination of clinical and legal pneumoconiosis caused hypoxemia, pulmonary hypertension, and cor pulmonale. He diagnosed cor pulmonale based on the Miner's chronic hypoxemia and echocardiograms and autopsy indicating pulmonary hypertension. Dr. Houser wrote that he believes "the elevated venous pressure secondary to right ventricular failure associated with cor pulmonale was a significant factor in the bleeding from the arterial venous malformations." He asserted that clinical and legal pneumoconiosis contributed to the Miner's death "as a result of increased work of breathing and diminished respiratory reserve." Despite the lack of recent pulmonary function data in the Miner's case, Dr. Houser quoted a publication finding that COPD "predisposes to death from any cause" and "time to death from any cause is highly associated with the degree of reduction in baseline FEV₁." On cross examination, Dr. Houser acknowledged that the Miner had a history of peptic ulcer disease, which can cause gastrointestinal bleeding and that the Miner took anti-coagulants, which can also contribute to gastrointestinal bleeding. CX 4; CX 5 at 24-26, 54-55.

Dr. Houser noted that the Miner began working in the mines in 1956 and that "from 1956 through at least 1969 there was no federal regulation regarding dust standards." He explained that the Miner's work at the tippie would have involved significant coal dust exposure. When asked whether one can have emphysema caused by coal dust that does not include proximity to dust macules, Dr. Houser responded, "Attfield and Hodous have said in their article from 1992 that even when the chest radiograph is negative that there's evidence of emphysema and airway obstruction on clinical findings." He stated that he finds it hard to believe that there can be enough coal dust to cause coal workers' pneumoconiosis, but yet not enough coal dust to cause emphysema. Dr. Houser read from a peer-reviewed article asserting that coal dust can produce emphysema independent of cigarette smoke exposure and explained an additional article concluding that coal dust exposure and cigarette smoking had similar additive effects on emphysema severity. He concluded that smoking and coal mine dust exposure significantly contributed to the Miner's emphysema. Finally, Dr. Houser quoted from a textbook, CLINICAL OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, regarding reduced ability to transfer gases in the lungs of miners. He noted that in some situations hypercapnia and hypoxemia result and that, "[i]n advanced disease, airflow obstruction may be so severe that alveolar ventilation is insufficient for metabolic demands." CX 4; CX 5 at 12-14, 32-38.

Dr. Houser did not believe the Miner's aortic stenosis affected his arterial blood gas studies or caused any significant change in pulmonary status; he believed the aortic stenosis was already treated with valve replacement surgery. He disagreed with Dr. Rosenberg's opinion that diastolic dysfunction caused the Miner's right-sided heart failure²⁵ because Dr. Rosenberg's opinion does not factor in the effect of clinical pneumoconiosis and emphysema, which were

²⁵ Dr. Houser explained that the most common cause of right ventricular failure is left ventricular failure, but that when right-sided problems are secondary to lung disease or pressure overload on the right side, then the condition is called cor pulmonale. "If the left side of the heart is involved, that's not cor pulmonale." CX 5 at 57-58.

both observed on autopsy and diagnosed clinically in the Miner's case and are both known to cause cor pulmonale. Regarding Dr. Oesterling's findings of silica crystals in the Miner's lungs, Dr. Houser explained, "to have silica crystals in the lung, that means that [Miner], during his lifetime, inhaled silica. The silica is basically sand or rock dust. This is a common finding in coal miners because we do not refer to coal dust as coal dust, it's coal mine dust, because up to five percent of it is composed of silica." He testified that coal workers' pneumoconiosis can progress even after a miner's last exposure. CX 5 at 21, 38-42, 45-47.

Dr. David Rosenberg. EX 3, 7.

Dr. Rosenberg opined that the Miner had minimal clinical coal workers' pneumoconiosis, discernable only pathologically, and no associated pulmonary disability. Indeed, Dr. Rosenberg commented that one pathologist, Dr. Oesterling, did not even observe coal macule formation on autopsy. Dr. Rosenberg acknowledged that smoking and coal mine dust exposure cause emphysema. However, in the Miner's case, Dr. Rosenberg stated that the emphysema noted on autopsy was not associated with coal dust deposition. He concluded that coal dust exposure did not cause the emphysema and, thus, that the emphysema did not constitute legal pneumoconiosis. Dr. Rosenberg attributed the Miner's emphysema to his smoking history. He opined that the Miner did not suffer from a respiratory disability, but rather was disabled due to his heart disease.

According to Dr. Rosenberg, the Miner "developed critical aortic stenosis, requiring valve replacement, followed by recurrent episodes of right-sided congestive heart failure in association with pulmonary hypertension" with overall preserved left ventricular function. Dr. Rosenberg opined that the etiology of the Miner's right-sided congestive heart failure was multifactorial, but unrelated to coal dust exposure. In his medical report, he stated, "[a] major factor contributing to his pulmonary hypertension and resultant right sided heart failure was diastolic dysfunction."²⁶ When asked about the cause of death at the deposition, Dr. Rosenberg stated, "[t]he cause of death was constrictive pericarditis, was the main factor, leading to right-sided heart failure, compounded with the other factors that I talked about, causing pulmonary hypertension, the sleep apnea, the stiffness that can affect the muscle of the heart from aortic stenosis, the hypertension, all these factors leading to right-sided heart failure, and he ended up dying eventually, ultimately from total body failure, from heart failure." He noted that the autopsy confirmed constrictive pericarditis.

He did not attribute the Miner's right-sided heart failure to a lung problem because he did not see indications of loss of the alveolar capillary bed which would create pulmonary hypertension. Dr. Rosenberg asserted that the Miner's normal exercise blood gases prove that

²⁶ Dr. Rosenberg explained that diastolic dysfunction is known to lead to right-sided heart failure because the stiff left ventricle causes a pressure backup which is transferred to the right side of the heart. As diastolic dysfunction causes right-sided heart failure, so too does aortic stenosis cause left ventricular diastolic dysfunction, which can also be "potentiated after aortic valve replacement." These conditions, as well as constrictive pericarditis and inadequately treated obstruction sleep apnea, led to Miner's right-sided heart failure, Dr. Rosenberg asserted. Based on the Miner's pulmonary artery pressure and wedge pressure measurements, Dr. Rosenberg opined that the left ventricle was not relaxing, which caused increased pressure and required the Miner's heart to beat more. He also noted equalization pressures at rest, which, in his opinion, confirmed constriction of the pericarditis. EX 3; EX 7 at 13-14, 17-18.

his alveolar capillary bed within the lungs was intact: “[w]ith an intact capillary bed, [Miner’s] CWP did not result in the development of increased vascular pressures against which the right side of his heart had to push. As such CWP did not contribute to his pulmonary hypertension.” According to Dr. Rosenberg, the Miner had no obstruction, no restriction, normal gas exchange with exercise, minimal coal workers’ pneumoconiosis, and only minimal emphysema which would be insufficient to cause loss of the alveolar capillary bed. He opined that emphysema has to affect about a third of the lungs before it causes significant impairment and the Miner’s emphysema was minimal and also not associated with coal dust, and, in his opinion, thus, not legal pneumoconiosis. Dr. Rosenberg acknowledged that emphysema is a form of COPD and that COPD can be associated with pulmonary hypertension and can cause cor pulmonale. He maintained that there are other causes of cor pulmonale including sleep apnea and constrictive pericarditis.

Citing a study by Fernie, Dr. Rosenberg stated that cor pulmonale is only associated with advanced coal workers’ pneumoconiosis. Thus, Dr. Rosenberg concluded that the Miner’s minimal coal workers’ pneumoconiosis observed pathologically “did not cause or contribute to his development of pulmonary hypertension, and resultant cor pulmonale.” He disagreed with Dr. Smith²⁷ that coal workers’ pneumoconiosis causes development of AV malformations, and referenced a study by Enns to support his position.

Regarding the cause of the AV malformations, Dr. Rosenberg surmised that age or aortic stenosis may explain the development in the Miner’s case. He stated that, unlike the Miner’s death certificate, the autopsy did not show endocarditis. Overall, Dr. Rosenberg found that the Miner’s death was not caused or hastened by coal mine dust exposure. Dr. Rosenberg agreed that the increase in venous pressure and anticoagulation medication caused the Miner to bleed more severely through his AVM, aggravating his condition. EX 3; EX 7 at 8-16, 22-27, 30-36.

Dr. Kirk Hippensteel. EX 4, 6.

Based on his review of medical records, Dr. Hippensteel concluded that the Miner had minimal simple clinical pneumoconiosis based on his autopsy, noting that autopsies are the “most sensitive and specific test for the presence or absence of pneumoconiosis.” He asserted that the simple pneumoconiosis did not have any clinically significant effect on the Miner’s lung or heart function and did not contribute to his death. Similarly, Dr. Hippensteel opined that the Miner did not have an obstructive impairment during his lifetime to support the historical diagnoses of COPD in his medical records. Thus, he asserted that there was no clinical significance of the emphysema observed at autopsy based on the few pulmonary function test results in the Miner’s records he reviewed. Dr. Hippensteel noted that the emphysema on autopsy could have been due to smoking or coal mine dust exposure. He opined that chronic right pleural effusion was the cause for the restrictive impairment from which the Miner suffered. He asserted that the Miner suffered from multiple severe diseases unrelated to coal mine dust exposure which caused his death. EX 4; EX 6 at 20-21.

²⁷ Dr. Rosenberg noted disagreement with Dr. Lynn; it appears that he intended to say Dr. Lynn Smith.

He attributed the Miner's right-sided heart failure to heart disease rather than to lung disease. Specifically, Dr. Hippensteel asserted that the Miner underwent surgery for aortic valve replacement and then suffered from left-sided heart failure, ongoing congestive heart failure, and pleural effusions after the surgery. Consequently, he stated, back pressure into the lungs related to severe stenosis created pulmonary venous hypertension, one of the significant causes for pulmonary arterial hypertension, and the Miner suffered from heart damage (found on autopsy in both his left heart and right side of his heart) unrelated to cor pulmonale or lung disease. He noted that the Miner had infarcts on the left and right side of his heart. Dr. Hippensteel further stated, after the aortic valve replacement, the Miner underwent surgery for his pericarditis in 2000. According to Dr. Hippensteel, the findings of inflammation and scarring outside of the heart at autopsy suggest that the surgery did not completely correct the problem. Additionally, Dr. Hippensteel opined that the Miner's sleep apnea, atrial fibrillation, and arterial venous malformations also related to or contributed to his heart trouble. In particular, Dr. Hippensteel maintained that aortic stenosis and renal failure are associated with arterial venous malformations. He disagreed with Dr. Smith's explanation that the Miner's COPD caused the bleeding; rather Dr. Hippensteel believed that the Miner did not have cor pulmonale and did not have issues from COPD that caused bleeding from his intestinal tract. *Id.* at 11-18, 23.

He opined that the Miner used supplemental oxygen for his heart disease. *Id.* at 42. Dr. Hippensteel related that the Miner had significant coal mine dust exposure and a significant smoking history. *Id.* at 14. He stated that cigarette smoking, unlike coal dust exposure, produces a risk for left-sided heart disease. *Id.* On cross examination, Dr. Hippensteel agreed that emphysema, COPD, and coal workers' pneumoconiosis can cause cor pulmonale. *Id.* at 35.

Other Medical Evidence

CT Scans. DX 16.

Date of CT scan	Date Read	Ex. No.	Physician	Radiological Credentials	Interpretation
09/04/2008	09/04/2008	DX 16	Skelton	Not provided	Moderately sized layering right pleural effusion with associated atelectasis; lungs otherwise clear; no focal consolidation; no pneumothorax; no pleural thickening; cardiomegaly; several pericardial calcifications; calcification of the aortic valve and mitral annulus; extensive calcific atherosclerosis; of thoracic aorta

Death Certificate. CX 7/ DX 13.

The Miner's death certificate states that the immediate cause of death was renal failure with underlying causes of congestive heart failure and infective endocarditis.

Treatment Records. CX 1; DX 16.CX 1

Chest X-ray interpretations from June 1987, January, March, and October 1999, May 2000, January 2001, and October 2005 recorded findings consistent with COPD or emphysema. *Id.* at 1, 62, 134, 152, 344, 346, 347, 353, 355, 394. A chest X-ray interpretation dated 08/17/2000 recorded an impression of underlying interstitial lung disease. *Id.* at 345. Many X-ray interpretations from 1999-2001 and 2005 found right pleural effusion, cardiomegaly, or venous congestion; moreover, numerous interpretations were deemed consistent with congestive heart failure. *See, e.g., id.* at 1, 58-61, 134, 152-53, 344-55. Similarly, the records, in many places, note a history of COPD or pneumoconiosis, but do not include any supporting information to substantiate the diagnosis. *See, e.g., id.* at 5, 12, 17, 21, 138, 275.

Central to this matter is whether lung disease caused the Miner's heart failure and complications or whether a cardiac problem, unrelated to any lung disease, caused heart failure. Dr. Smith's treatment records at first diagnose right-sided heart failure due to restrictive pericarditis. For example, in May and June 2003, Dr. Smith wrote that the Miner had congestive heart failure predominantly on the right side due to a restrictive pericarditis with some left-sided failure. *Id.* at 37, 43. Similarly, on June 13, 2003, Dr. Smith stated, "[a]s before, his failure though has always been right sided related to his restrictive pericarditis." *Id.* at 40. Likewise, discharge summaries dated 01/22/2004 and 02/01/2004 opined that the Miner suffered from congestive heart failure secondary to acute diastolic dysfunction and diastolic dysfunction with restrictive pericarditis. *Id.* at 25-27. Thus, I find that Dr. Smith attributed the congestive heart failure to restrictive pericarditis and not to lung disease on these occasions.

On the other hand, the February 2004 discharge summary noted that the Miner had good left ventricular function and the January 2004 discharge summary reported severe chronic lung disease with pulmonary hypertension. *Id.* A 07/02/2003 echocardiogram showed normal left ventricular function with mild left ventricular hypertrophy, right ventricular enlargement and decreased right ventricular function. *Id.* at 36.

In later years, Dr. Smith's theory appears to have shifted. In January 2007, Dr. Smith wrote that the Miner had a "history of severe congestive heart failure due to a combination of pulmonary hypertension, pneumoconiosis, and cor pulmonale." *Id.* at 186. In April 2007, Dr. Smith attributed the Miner's arteriovenous malformations to pulmonary hypertension and cor pulmonale. *Id.* at 263. Finally, a 03/29/2007 history and physical report recorded that the Miner had a history of pulmonary hypertension, cor pulmonale, due to a combination of restrictive lung disease and valvular heart disease. *Id.* at 266.

DX 16

DX 16 includes interpretations of multiple X-rays from August 2008 finding the following: moderate right pleural effusion with associated atelectasis, pulmonary venous congestion, cardiomegaly, and hazy opacity left lateral lower lung zone secondary to atelectasis. DX 16 X-ray reports dated 08/30/2008, 08/28/2008, 08/18/2008, 08/11/2008, 08/05/2008,

08/02/2008. The X-ray interpretations did not state that the Miner had emphysema or coal workers' pneumoconiosis. An X-ray dated 08/12/2006 revealed pulmonary fluid overload, moderate right-sided pleural effusion, enlarged cardiac silhouette, and pulmonary vascular congestion. Similarly, the X-ray interpretations dated 02/18/2004, 07/10/2003, and 07/09/2003 found right pleural effusion. A 05/23/2002 X-ray showed near complete white out of the right lung with some volume loss and cardiomegaly. A 01/22/2001 X-ray showed enlarged cardiac silhouette, moderate right pleural effusion, and mild pulmonary venous congestion without evidence of pulmonary edema.

Discussion

The record evidence suggests a smoking history of 80 pack-years with cessation around 2007. Dr. Smith's records include varied estimations from 30 pack-years (CX 1 at 135) to 60 pack-years (CX 1 at 196). However, Dr. Smith's records also note that the Miner quit and resumed smoking and suggest that the Miner may have underreported his smoking habit. See CX 1 at 5, 135, 186, 191, 196. Most reports included in the University of Virginia records include an 80 pack-year history of smoking. DX 16 at 08/24/2008 Discharge Summary; 09/22/2008 Consult Note; 09/01/2008 Consult Note; 05/30/2002 Discharge Summary; 12/24/2000 Discharge Summary. Likewise, Dr. Smith, who treated the Miner for about 25 years, testified that the Miner likely smoked 70 to 80 pack-years. Thus, I find that the Miner likely smoked about 80 pack-years.

As above, I afford controlling weight to Dr. Smith's well-reasoned opinion as the Miner's treating physician that the Miner suffered from clinical and legal pneumoconiosis and that the Miner's underlying lung disease contributed to his death. For the reasons stated above, I find that Dr. Smith obtained superior and relevant information concerning the Miner's condition during his 25 years observing and evaluating the Miner as the Miner's treating physician. I note that Dr. Smith's conclusions are consistent with the autopsy evidence of simple clinical pneumoconiosis, emphysema, and pulmonary hypertension. While Dr. Smith may have based his original diagnosis of coal workers' pneumoconiosis on the Miner's stated history, he testified at his deposition that he considered the autopsy findings when presenting his opinion in this matter. His opinion that the Miner's right-sided heart failure was due to progressive lung disease, including pneumoconiosis and COPD, is, furthermore, consistent with his medical reports from 2007 attributing congestive heart failure to pulmonary hypertension, pneumoconiosis, and cor pulmonale.

I note that Dr. Smith at first attributed the right-sided failure to restrictive pericarditis in 2003 and 2004. However, he persuasively testified that the restrictive pericarditis was corrected while the lung disease was progressive. Thus, he concluded that lung disease was the more likely cause of the progressive right-sided failure, also citing the Miner's normal left ventricular function as demonstrated on various echocardiograms. I find that his opinion is reasonable and consistent with the records at CX 1 as they developed over time. Similarly, I find that, even though Dr. Smith could not apportion the amount of impairment due to cigarette smoking versus coal mine dust exposure, his opinion that the two exposures both significantly contributed to the Miner's lung disease is reasonable and comports with the Department's findings regarding the additive effect of coal mine dust exposure and smoking. See *Stiltner v. Harman Mining*

Corporation, BRB No. 10-0702 BLA (Sept. 30, 2011); 65 Fed. Reg. 79,920, 79,939 (Dec. 20, 2000).

Finally, I find that Dr. Smith's conclusion that the Miner's coal mine dust induced lung disease contributed to his death is reasonable because it takes into account the Miner's multiple medical problems and reasonably explains how lung disease contributed to the Miner's death by increasing venous pressure and worsening the bleeding from the arteriovenous malformations. Thus, I afford controlling weight to Dr. Smith's opinion that the Miner suffered from clinical and legal pneumoconiosis which contributed to his death.

Like Dr. Smith, Dr. Houser opined that the Miner suffered from clinical and legal pneumoconiosis and cor pulmonale and that his lung disease contributed to his death. He based his opinion on a review of extensive medical records, including Dr. Smith's treatment notes. I find that Dr. Houser's opinion is well-reasoned and I afford it full weight. In particular, I note that Dr. Houser's opinion comports with the Department's findings regarding the additive effect of cigarette smoking and coal mine dust exposure and is consistent with the autopsy evidence of simple clinical pneumoconiosis and emphysema. *See* 65 Fed. Reg. 79,920, 79,939 (Dec. 20, 2000). His explanation of how the Miner's limited respiratory reserve and increased venous pressure from cor pulmonale contributed to the Miner's death is well-reasoned and takes into account the Miner's complex medical condition.

As above, I afford little weight to the opinions of Drs. Rosenberg and Hippensteel because they reviewed less extensive documentation. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be given to an opinion supported by more extensive documentation over an opinion supported by limited medical data). These doctors lacked the benefit of reviewing additional evidence of disability or impairment; thus, their determinations regarding the lack of impairment are less reliable. *See Osborne v. Clinchfield Coal Co.*, BRB No. 96-1523 BLA (Apr. 30, 1998) (*en banc* on recon.) (unpub.). Hence, their opinions of the contribution of lung disease to the Miner's death are based on less extensive information regarding the Miner's overall condition. Their conclusions that the pneumoconiosis and emphysema observed on autopsy did not contribute to the Miner's death based on his normal function are less probative because they did not consider Dr. Smith's treatment records. Without the opportunity to consider the hypoxia, oxygen dependency, and evidence of resolution of the restrictive pericarditis, Dr. Rosenberg and Dr. Hippensteel are not able to persuasively rule out pneumoconiosis and emphysema, or coal mine employment generally, as factors which contributed to the Miner's death.

I find that the CT scan and the X-rays in the treatment records do not diagnose coal workers' pneumoconiosis. However, I find that the autopsy evidence is more probative and demonstrated the presence of both clinical pneumoconiosis and emphysema. Similarly, I find that the death certificate does not mention pneumoconiosis, emphysema, or COPD, but is outweighed by the more thorough evidence of record such as the well-reasoned physician opinions finding that pneumoconiosis contributed to the Miner's death. On the one hand, the treatment records generally do not establish a diagnosis of clinical or legal pneumoconiosis because they do not include a well-supported opinion diagnosing the presence of the diseases. On the other hand, they do corroborate Dr. Smith's and Dr. Houser's well-reasoned opinions

with X-ray evidence of COPD, echocardiograms showing normal left ventricular function, statements that the Miner was on supplemental oxygen, and information which corroborates the diagnosis of cor pulmonale and right-sided congestive heart failure. Consequently, these records do not rule out the presence of clinical or legal pneumoconiosis and do not rule out coal mine employment as a cause of the Miner's death.

I have afforded controlling weight to Dr. Smith's opinion and full weight to Dr. Houser's opinion. Conversely, I have afforded little weight to Dr. Rosenberg's and Dr. Hippensteel's opinions. Finally, I have determined that the treatment and hospitalization records as well as the CT scan evidence and autopsy evidence generally support Dr. Smith's and Dr. Houser's opinions. I find that the Miner suffered from clinical and legal pneumoconiosis and that coal mine employment contributed to his death. Consequently, the Employer has not rebutted the presumption by preponderantly establishing that the Miner did not have clinical or legal pneumoconiosis or by ruling out coal mine employment as a cause of the Miner's death.

3. Pneumoconiosis Arising Out of Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). The rebuttable presumption pertains only to clinical pneumoconiosis. *See Andersen v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006).

In this case, I have found more than 10 years of coal mine employment. I have also found clinical and legal pneumoconiosis based on Dr. Smith's and Dr. Houser's opinions. The Employer has not put forward any evidence that the Miner's clinical pneumoconiosis did not arise out of coal mine employment. Accordingly, Claimant has established that the Miner had pneumoconiosis arising out of coal mine employment.

4. Death Due To Pneumoconiosis

Pursuant to 20 C.F.R. § 718.205, Claimant must demonstrate that the miner's death was caused by pneumoconiosis. Notably, a survivor is not entitled to benefits "where the miner's death was caused by traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death." 20 C.F.R. § 718.205(c)(4). The regulation further provides that pneumoconiosis is a "substantially contributing cause of a miner's death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5).

A survivor must present evidence sufficient to demonstrate that the miner's death was caused by pneumoconiosis if: (1) the survivor's claim does not meet the requirements for automatic entitlement;²⁸ and (2) the survivor does not qualify for invocation of either of the presumptions at 20 C.F.R. §§ 718.304 and 718.305. Because the Claimant successfully invoked

²⁸ Where the miner was finally awarded benefits on a lifetime claim, and the survivor's claim is filed after January 1, 2005 and is pending on or after March 23, 2010, the survivor is automatically entitled to benefits. In this case, however, the Miner was not awarded benefits on a lifetime claim.

the § 718.305 presumption, and the Employer did not rebut the presumption, the Claimant has established that Miner died due to pneumoconiosis.

5. Responsible Operator

The Employer asserted that it is not the responsible operator because the Miner more recently worked for another operator, Lady H, for a period of more than one year. Employer's Brief at 2-3. The Director, Office of Workers' Compensation Programs, responded that Lady H was not covered by a policy of insurance and was not self-insured on the date on which it last employed the miner and, moreover, Lady H declared bankruptcy and its assets were purchased by Green Valley Coal Company free and clear of any liability per the US Bankruptcy Court Southern District West Virginia. Director's Brief at 1 (citing DX 30). According to the District Director in the Proposed Decision and Order, Lady H's insurance policy was canceled on March 16, 1994 before the Miner's last date of employment on July 1, 1994 and there was no evidence that Lady H obtained other insurance afterward; the Proposed Decision and Order indicates that Lady H's assets were acquired in 1996 free and clear of liability. DX 30.

The Employer argued that liability should fall to the trust fund because either 1) a fund was set up in bankruptcy and it was insufficiently funded or 2) the Department of Labor failed to participate in the bankruptcy process. Employer's Brief at 3. The Director countered that there is no obligation to ensure that a more recent but bankrupt operator secures its future liability during bankruptcy for the payment of benefits. Director's Brief at 2 (citing *Armco, Inc. v. Martin*, 277 F.3d 468, 473 (4th Cir. 2002)).

I agree with the Director that, pursuant to 20 C.F.R. § 725.494(e), an operator can only be a potentially liable operator if "[t]he operator is capable of assuming its liability for the payment of continuing benefits under this part." The regulations further provide that an operator is capable of assuming liability if one of the following three conditions is met: (1) the operator obtained a policy or contract of insurance; (2) the operator qualified as a self-insurer; or (3) the operator possesses sufficient assets to secure the payment of benefits. § 725.494(e)(1)-(3). I also agree that, in *Martin*, the Fourth Circuit stated that it "would have no legal authority to require payment from the Trust Fund based on the Director's failure to ensure that [an operator] would be able to pay any future liability." 277 F.3d at 473. Thus, I find that Lady H would have to be capable of assuming liability to be the responsible operator and that Employer is the next operator for which the Miner worked.

The record evidence shows that Lady H was the last employer for which the Miner worked for a period of more than one year, but does not show that Lady H was capable of assuming its liability. At the District Director level, the Employer submitted a UMWA Certificate of Retirement showing that Miner last worked on July 1, 1994 and a Mine Workers Employment History showing the Miner worked from 1986 to 1994 for Lady H. DX 28; see also DX 8 (Social Security record showing employment with Lady H from 1986 to 1994). Employer also submitted evidence that the mine Lady H operated transferred to Green Valley Coal Company on May 20, 1996. DX 28. By letters dated February 17, 2009 and July 24, 2009, the Employer asserted that Lady H was insured by the CWP Fund Account Number 73000031

and was a subsidiary of Consolidated Sewell Inc. *Id.* The Employer did not include any documentation to support those assertions.

The record also includes Lady H's response to the Notice of Claim indicating that it was insured by WV CWP Fund policy number 73000031-302 from April 1, 1986 to March 16, 1994. DX 26. Workers' compensation specialist, Beverly A. Branch, signed the 20 C.F.R. §725.495 statement that Lady H was not insured or self-insured on the date on which it last employed the Miner. DX 19.

Based on the foregoing, I find that Employer is the responsible operator because the more recent potentially liable operator, Lady H, is not able to assume liability. The evidence suggests that Lady H's insurance policy ended before the Miner's last date of employment and that in 1996 Lady H was acquired by Green Valley Coal Company, as the District Director asserted. There is no record evidence to establish that Lady H obtained insurance, became self-insured, or can assume payment.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has established entitlement to benefits under the Act because she has established that the Miner suffered from pneumoconiosis arising out of coal mine employment and that the Miner's death was due to pneumoconiosis.

V. ONSET DATE

Benefits are payable as of September 2008, the month in which Miner died. 20 C.F.R. § 725.503(c).

VI. ATTORNEY'S FEE

The award of a representative's fee under the Act is permitted only in cases in which a claimant is found entitled to benefits. Since benefits are awarded in this case, the Claimant's representative is entitled to a fee for representation services rendered in pursuit of the claim.

No award of fees for services to the Claimant is made herein because no fee application has been received. Thirty (30) days is hereby allowed the Claimant's counsel for the submission of a fee application which must conform to §§ 725.365 and 725.366 of the Regulations. A service sheet showing that service has been made upon all parties including the Claimant must accompany the application. Parties have ten (10) days following receipt of any such application within which to file any objection. The Act prohibits the charging of a fee in the absence of an approved application.

VII. ORDER

The Claimant's claim for benefits under the Act is AWARDED. Benefits are payable as of September 2008. 20 C.F.R. § 725.503(c).



Digitally signed by LYSTRA HARRIS
DN: CN=LYSTRA HARRIS,
OU=Administrative Law Judge, O=Office
of Administrative Law Judges,
L=CHERRY HILL, S=NJ, C=US
Location: CHERRY HILL NJ

LYSTRA A. HARRIS
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, PO Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

SERVICE SHEET

Case Name: FITZWATER_PATRICIA_A_v_WESTMORELAND_COAL_an_

Case Number: 2010BLA05364

Document Title: **DECISION AND ORDER AWARDING BENEFITS**

I hereby certify that a copy of the above-referenced document was sent to the following this 3rd day of April, 2014:



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BRB No. 14-0261 BLA

PATRICIA F. FITZWATER
(Widow of JACKIE L. FITZWATER)

Claimant-Respondent

v.

WESTMORELAND COAL COMPANY

Employer-Petitioner

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS, UNITED
STATES DEPARTMENT OF LABOR

Party-in-Interest

NOT PUBLISHED

DATE ISSUED: APR 29 2015

DECISION and ORDER

Appeal of the Decision and Order of Lystra A. Harris, Administrative Law
Judge, United States Department of Labor.

Timothy C. MacDonnell (Black Lung Legal Clinic, Washington & Lee
University School of Law), Lexington, Virginia, for claimant.

Paul E. Frampton (Bowles Rice LLP), Charleston, West Virginia, for
employer.

Jeffrey S. Goldberg (M. Patricia Smith, Solicitor of Labor; Rae Ellen
James, Associate Solicitor; Michael J. Rutledge, Counsel for
Administrative Litigation and Legal Advice), Washington, D.C., for the
Director, Office of Workers' Compensation Programs, United States
Department of Labor.

Before: HALL, Chief Administrative Appeals Judge, McGRANERY and
BOGGS, Administrative Appeals Judges.

PER CURIAM:

Employer appeals the Decision and Order (2010-BLA-5364) of Administrative

Law Judge Lystra A. Harris awarding benefits on a claim filed pursuant to the provisions of the Black Lung Benefits Act, as amended, 30 U.S.C. §§901-944 (2012) (the Act). This case involves a survivor's claim filed on January 18, 2009.

After crediting the miner with at least twenty-nine years of qualifying coal mine employment,¹ the administrative law judge found that the miner had a totally disabling respiratory impairment pursuant to 20 C.F.R. §718.204(b)(2). The administrative law judge, therefore, determined that claimant² invoked the rebuttable presumption that the miner's death was due to pneumoconiosis set forth at amended Section 411(c)(4) of the Act.³ 30 U.S.C. §921(c)(4).⁴ The administrative law judge further found that employer did not rebut the presumption. Accordingly, the administrative law judge awarded benefits.

¹ The miner's coal mine employment was in West Virginia. Director's Exhibit 6. Accordingly, this case arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit. See *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc).

² Claimant is the surviving spouse of the miner, who died on September 24, 2008. Director's Exhibit 13.

³ Congress enacted amendments to the Black Lung Benefits Act, which apply to claims filed after January 1, 2005, that were pending on or after March 23, 2010. Relevant to this case, Congress reinstated Section 411(c)(4) of the Act, which provides a rebuttable presumption that a miner's death was due to pneumoconiosis in cases where fifteen or more years of qualifying coal mine employment and a totally disabling respiratory impairment are established. 30 U.S.C. §921(c)(4). The Department of Labor revised the regulations to implement the amendments to the Act. The revised regulations became effective on October 25, 2013, and are codified at 20 C.F.R. Parts 718, 725 (2014).

⁴ The amendments also revived Section 422(l) of the Act, 30 U.S.C. §932(l), which provides that a survivor of a miner who was determined to be eligible to receive benefits at the time of his or her death is automatically entitled to receive survivor's benefits without having to establish that the miner's death was due to pneumoconiosis. 30 U.S.C. §932(l). The miner filed a claim in 1978. On December 10, 1982, the district director informed the miner that he would be entitled to benefits if he terminated his coal mine employment within one year. The miner's employment records, however, indicate that the miner did not terminate his coal mine employment within the one year time period. Director's Exhibit 6. Thus, claimant cannot benefit from this provision, as the miner was not eligible to receive benefits at the time of his death.

On appeal, employer argues that the administrative law judge erred in identifying it as the responsible operator. Employer also argues that the administrative law judge erred in finding that the evidence established total disability pursuant to 20 C.F.R. §718.204(b)(2) and, therefore, erred in finding that claimant invoked the Section 411(c)(4) presumption. Employer further contends that the administrative law judge erred in finding that employer did not rebut the Section 411(c)(4) presumption. Claimant responds in support of the administrative law judge's award of benefits. The Director, Office of Workers' Compensation Programs (the Director), responds in support of the administrative law judge's identification of employer as the responsible operator.⁵

The Board's scope of review is defined by statute. The administrative law judge's Decision and Order must be affirmed if it is rational, supported by substantial evidence, and in accordance with applicable law. 33 U.S.C. §921(b)(3), as incorporated by 30 U.S.C. §932(a); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

Benefits are payable on survivors' claims when the miner's death is due to pneumoconiosis. See 20 C.F.R. §§718.1, 718.205; *Neeley v. Director, OWCP*, 11 BLR 1-85 (1988). A miner's death will be considered to be due to pneumoconiosis if pneumoconiosis was the cause of the miner's death, pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, death was caused by complications of pneumoconiosis, the presumption relating to complicated pneumoconiosis set forth at 20 C.F.R. §718.304 is applicable, or the Section 411(c)(4) presumption is invoked and not rebutted. 20 C.F.R. §718.205(b)(1)-(4). Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. 20 C.F.R. §718.205(b)(6).

Responsible Operator

Employer, Westmoreland Coal Company, challenges its designation as the responsible operator. Section 725.495 addresses the burden of proof of the parties with regard to the criteria for determining the responsible operator, and specifically provides that the Director bears the burden of proving that the responsible operator initially found liable for the payment of benefits is the potentially liable operator that most recently employed the miner. 20 C.F.R. §725.495(a), (b). The regulation also provides that in any case in which the designated responsible operator is not the operator that most recently employed the miner, the district director is required to explain the reasons for

⁵ Employer does not challenge the administrative law judge's finding that claimant established that the miner had at least twenty-nine years of qualifying coal mine employment. This finding is, therefore, affirmed. See *Skrack v. Island Creek Coal Co.*, 6 BLR 1-710, 1-711 (1983).

such designation. To set forth a prima facie case that the most recent operators are incapable of paying benefits, the district director need only include within the record a statement that the Office of Workers' Compensation Programs has searched its files and found no record of insurance coverage or authorization to self-insure for those operators. 20 C.F.R. §725.495(d).

The district director designated employer, Westmoreland Coal Company, as the responsible operator because the miner's more recent employer, Lady H Coal Company, was uninsured at the time of the miner's last employment with them. 20 C.F.R. §725.495(a)(3); Director's Exhibit 30. As the administrative law judge accurately noted, the record contains the required statement from the Office of Workers' Compensation Programs that Lady H Coal Company was uninsured and lacked authorization to self-insure at the time of the miner's last employment. Decision and Order at 35; Director's Exhibit 19. Moreover, the district director in this claim reiterated in the Proposed Decision and Order that Lady H Coal Company was uninsured at the time of the miner's last employment with the company.⁶ Director's Exhibit 30. Employer does not offer any evidence to meet its burden as the designated responsible operator, under 20 C.F.R. §725.495(c), of proving that Lady H Coal Company is a potentially liable operator, pursuant to 20 C.F.R. §725.494. We, therefore, affirm the administrative law judge's designation of employer as the responsible operator in this claim.

⁶ In declining to identify Lady H Coal Company as the responsible operator, the district director explained that:

Lady H Coal Company was insured by [the West Virginia Coal Workers' Pneumoconiosis] Fund, but the policy was cancelled on March 16, 1994 ~~and there is no evidence that Lady H Coal Company obtained insurance~~ after the policy was cancelled. This means that on the date of the last exposure Lady H Coal Company was uninsured. Lady H Coal Company declared bankruptcy and its assets were acquired in 1996 by Green Valley Coal Company, a subsidiary of A.T. Massey. The assets of Lady H Coal Company were purchased free and clear of any liability per the U.S. Bankruptcy Court [for the] Southern District [of] West Virginia. Based on this information, Lady H Coal Company cannot be named [the] responsible operator.

Director's Exhibit 30.

Invocation of the Section 411(c)(4) Presumption

Employer contends that the administrative law judge erred in finding that the evidence established total disability pursuant to 20 C.F.R. §718.204(b)(iii), (iv) and, therefore, erred in finding that claimant invoked the Section 411(c)(4) presumption.⁷

Pursuant to 20 C.F.R. §718.204(b)(2)(iii), a claimant may establish that a miner was totally disabled by offering medical evidence establishing that the miner suffered from cor pulmonale with right-sided congestive heart failure. Dr. Smith, the miner's treating physician, opined that the miner suffered from cor pulmonale with right-sided congestive heart failure due to coal workers' pneumoconiosis and emphysema. Claimant's Exhibits 2, 3. Based upon an extensive review of the medical evidence, Dr. Houser similarly opined that the miner suffered from cor pulmonale with right-sided congestive heart failure due to coal workers' pneumoconiosis and emphysema. Claimant's Exhibits 4, 5. Although Dr. Rosenberg diagnosed cor pulmonale with right-sided congestive heart failure, he opined that it was "multifactorial in etiology, but unrelated to past coal dust exposure." Employer's Exhibit 3. Dr. Hippensteel opined that the miner did not suffer from cor pulmonale. Employer's Exhibit 6 at 35.

In weighing the conflicting evidence, the administrative law judge found that Dr. Smith's opinion, that the miner suffered from cor pulmonale with right-sided congestive heart failure, was well reasoned, and supported by hospital records from the University of Virginia. Decision and Order at 7. The administrative law judge also accorded greater weight to Dr. Smith's opinion based upon his status as the miner's treating physician. *Id.* The administrative law judge further credited the opinions of Drs. Smith and Houser over the opinions of Drs. Rosenberg and Hippensteel because he found that their opinions were based upon more extensive documentation. *Id.* at 7-8. The administrative law judge, therefore, found that the evidence established total disability pursuant to 20 C.F.R. §718.204(b)(2)(iii).

Employer argues that the administrative law judge erred in failing to explain her basis for finding that the evidence established that the miner's right-sided congestive heart failure was due to lung disease.⁸ We disagree. The administrative law judge noted that, although Dr. Smith initially attributed the miner's right-sided congestive heart failure to restrictive pericarditis, Claimant's Exhibit 1 at 37, 43, the doctor subsequently

⁷ The administrative law judge found that the pulmonary function study and arterial blood gas study evidence did not establish total disability pursuant to 20 C.F.R. §718.204(b)(2)(i),(ii). Decision and Order at 5-6.

⁸ Claimant agrees with employer that cor pulmonale encompasses only right-sided congestive heart failure that is caused by lung disease. Claimant's Brief at 8.

opined that the condition was attributable to the miner's lung disease. The administrative law judge noted that Dr. Smith explained that, after the miner's pericardial disease had been treated,⁹ his congestive heart disease continued to progress, thereby leading him to attribute the miner's right-sided congestive heart failure, in part, to his lung disease. Decision and Order at 7; Claimant's Exhibit 3 at 45. The administrative law judge also accurately noted that Dr. Smith's diagnosis was supported by hospital records from the University of Virginia, which include a 2003 diagnosis of right-sided congestive heart failure due to multiple etiologies, including "sleep apnea, COPD [and] interstitial lung disease." Decision and Order at 7; Director's Exhibit 16. Because it is based on substantial evidence, we affirm the administrative law judge's finding that Dr. Smith's diagnosis of cor pulmonale with right-sided congestive heart failure is sufficiently reasoned. See *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 533, 21 BLR 2-323, 2-335 (4th Cir. 1998); *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269, 2-275-76 (4th Cir. 1997); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149, 1-155 (1989) (en banc); Decision and Order at 7. Having found that Dr. Smith's opinion was well-reasoned, the administrative law judge permissibly accorded greater weight to it based upon his status as the miner's treating physician.¹⁰ 20 C.F.R. §718.104(d); Decision and Order at 7, 15-17.

The administrative law judge also credited the opinions of Drs. Smith and Houser over the opinions of Drs. Rosenberg and Hippensteel because she found that they were based upon more extensive documentation, namely Dr. Smith's extensive treatment records.¹¹ Decision and Order at 7-8. In weighing medical reports, an administrative law

⁹ Dr. Smith explained that the miner's right-sided congestive heart failure continued to worsen after the miner underwent pericardial stripping to treat his pericarditis. Claimant's Exhibit 3 at 20-21. Dr. Houser similarly opined that the miner's treatment for pericarditis "would eliminate the complications associated with the pericarditis as masking other diseases." Claimant's Exhibit 5 at 44.

¹⁰ The administrative law judge noted that Dr. Smith was the miner's primary care physician from 1983 to 2008, during which he treated the miner for pulmonary problems, including chronic obstructive pulmonary disease, cor pulmonale, and chronic hypoxemia. Decision and Order at 8-9, 16. The administrative law judge noted that the doctor "ordered and reviewed many objective tests in the course of his treatment . . . and . . . saw the [m]iner two to four times per year in the beginning and as frequently as once or twice a month toward the end." *Id.* at 16-17.

¹¹ Dr. Smith's treatment records encompass over 1,000 pages, and include office notes, discharge summaries, x-ray interpretations, laboratory results, and objective tests from the 1980s to 2008. Claimant's Exhibit 1. As the administrative law judge notes, the "records diagnose and discuss multiple medical conditions such as gastrointestinal bleeding, atrial fibrillation, valve replacement, toxic shock syndrome, restrictive

judge may properly find that a doctor's opinion based on limited clinical data is entitled to less weight than conflicting reports based upon more comprehensive documentation. *See Sabett v. Director, OWCP*, 7 BLR 1-299 (1984); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). Because it is supported by substantial evidence, we affirm the administrative law judge's finding that the evidence established that the miner suffered from cor pulmonale with right-sided congestive heart failure pursuant to 20 C.F.R. §718.204(b)(2)(iii).

Employer next contends that the administrative law judge erred in finding that the medical opinion evidence established total disability pursuant to 20 C.F.R. §718.204(b)(2)(iv). The administrative law judge again considered the medical opinions of Drs. Smith, Houser, Rosenberg and Hippensteel. Drs. Smith and Houser opined that the miner was totally disabled from a pulmonary standpoint. Claimant's Exhibits 3 at 16, 5 at 53. Dr. Rosenberg, however, opined that the miner had no disability "from a pulmonary perspective." Employer's Exhibit 3. Dr. Hippensteel opined that, after a long history of working in the mines, the miner "had evidence of normal pulmonary function." Employer's Exhibit 6 at 26.

In weighing the conflicting medical opinion evidence, the administrative law judge found that Dr. Smith's opinion, that the miner was totally disabled from a pulmonary standpoint, was well reasoned. Decision and Order at 17. The administrative law judge also accorded greater weight to Dr. Smith's opinion based upon his status as the miner's treating physician. *Id.* The administrative law judge further credited the opinions of Drs. Smith and Houser, that the miner was totally disabled from a pulmonary standpoint, over the contrary opinions of Drs. Rosenberg and Hippensteel, because she found that their opinions were based upon more extensive documentation. *Id.* The administrative law judge, therefore, found that the medical opinion evidence established total disability pursuant to 20 C.F.R. §718.204(b)(2)(iv).

Employer argues that the administrative law judge erred in relying upon the opinions of Drs. Smith and Houser to support a finding of total disability because the doctors relied upon "treatment blood gas tests which were affected by other health

pericarditis, pneumoconiosis, hypertension, acute renal failure, congestive heart failure, chronic obstructive pulmonary disease, diabetes, obstructive sleep apnea, and pulmonary hypertension." *Id.* While Dr. Houser reviewed Dr. Smith's treatment records, Claimant's Exhibit 4, Drs. Rosenberg and Hippensteel did not review Dr. Smith's treatment records, and instead limited their review to Dr. Smith's December 31, 2008 medical report and February 29, 2012 deposition testimony. Employer's Exhibits 6 at 8, 7 at 39.

conditions, such as recent heart surgery, and toxic shock syndrome.”¹² Employer’s Brief at 15, citing *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131 (1986). Employer, however, did not dispute the relevance of this blood gas study evidence for purposes of determining total disability when this claim was pending before the administrative law judge. Employer’s objection will not be considered for the first time on appeal to the Board. See *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-49 (1990); *Oreck v. Director, OWCP*, 10 BLR 1-51, 1-54 (1987) (Levin, J., concurring). Furthermore, we note that unlike the physician’s opinion in *Casella*, 9 BLR at 1-134, Dr. Rosenberg’s opinion does not provide the requisite foundation for employer’s argument: a statement that the miner’s heart surgery and toxic shock syndrome fully account for the decline measured in the miner’s blood gas studies.¹³

The administrative law judge also noted that Drs. Smith and Houser did not rely exclusively on the blood gas study results to support their assessments of the miner’s pulmonary impairment. The administrative law judge noted that Drs. Smith and Houser also based their opinions, that the miner was totally disabled from a pulmonary standpoint, on the fact that the miner was on continuous supplemental oxygen for two or more years before his death. Decision and Order at 17. Because it is based on substantial evidence, we affirm the administrative law judge’s finding that the medical opinion evidence established total disability pursuant to 20 C.F.R. §718.204(b)(2)(iv).

Moreover, the administrative law judge properly weighed the evidence of cor pulmonale with right-sided congestive heart failure and the medical opinion evidence with the pulmonary function and blood gas study evidence, and found that, when weighed together, the evidence established total disability pursuant to 20 C.F.R.

¹² Dr. Smith interpreted a 1999 arterial blood gas study as revealing minimal hypercapnia; a 2001 arterial blood gas study as revealing increased hypercapnia and significant hypoxia even with oxygen supplementation; a 2002 arterial blood gas study as demonstrating evidence of respiratory failure requiring oxygen supplementation; and a 2004 arterial blood gas study as revealing hypercapnia and hypoxia requiring oxygen supplementation. Decision and Order at 9; Claimant’s Exhibit 1.

¹³ The administrative law judge noted that Dr. Smith opined that the miner’s heart surgery around the time of the 2001 arterial blood gas study should not have affected the results. Decision and Order at 9; Claimant’s Exhibit 3 at 33-34. While the administrative law judge observed that Dr. Smith acknowledged that the miner’s toxic shock syndrome affected the 2002 arterial blood gas study results, Decision and Order at 9 n.7; Claimant’s Exhibit 3 at 32, there is no evidence that the miner’s more recent 2004 arterial blood gas study results (interpreted as showing hypercapnia and hypoxia) were unreliable.

§718.204(b)(2).¹⁴ See *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986), *aff'd on recon.*, 9 BLR 1-236 (1987) (en banc); Decision and Order at 40. This finding is, therefore, affirmed.

In light of our affirmance of the administrative law judge's findings that claimant established over fifteen years of qualifying coal mine employment, and the existence of a totally disabling respiratory impairment pursuant to 20 C.F.R. §718.204(b)(2), we affirm the administrative law judge's finding that claimant invoked the rebuttable presumption of death due to pneumoconiosis at Section 411(c)(4). 30 U.S.C. §921(c)(4); 20 C.F.R. §718.305.

Rebuttal of the Section 411(c)(4) Presumption

Because claimant invoked the presumption of death due to pneumoconiosis at Section 411(c)(4), the burden of proof shifted to employer to establish rebuttal by disproving the existence of clinical and legal pneumoconiosis,¹⁵ or by proving that the miner's death did not arise out of, or in connection with, his coal mine employment. 30 U.S.C. §921(c)(4); *Copley v. Buffalo Mining Co.*, 25 BLR 1-81, 1-89 (2012). To prove that the miner's death did not arise from his coal mine employment, employer had to establish "that no part of the miner's death was caused by pneumoconiosis as defined in [20 C.F.R.] §718.201." 20 C.F.R. §718.305(d)(2)(ii); 78 Fed. Reg. at 59,115. The administrative law judge found that employer did not establish rebuttal by either method. Decision and Order at 33.

The administrative law judge found that employer failed to disprove the existence of clinical pneumoconiosis or legal pneumoconiosis. Decision and Order at 33. Employer's arguments on appeal focus on the extent and severity of the miner's clinical

¹⁴ The administrative law judge permissibly found that the "outdated" non-qualifying pulmonary function studies and arterial blood gas studies from 1979 and 1981 were "outweighed by the more recent and comprehensive evidence of record demonstrating that the [m]iner was totally disabled." Decision and Order at 18; see *Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 624, 11 BLR 2-147, 2-149 (6th Cir. 1988); *Parsons v. Wolf Creel Collieries*, 23 BLR 1-29, 1-35 (2004).

¹⁵ "Clinical pneumoconiosis" consists of "those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung to that deposition caused by dust exposure in coal mine employment." 20 C.F.R. §718.201(a)(1). "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. 20 C.F.R. §718.201(a)(2).

pneumoconiosis and legal pneumoconiosis, rather than on the existence of the diseases. Notably, employer contends that “the weight of the pathology evidence is that the *coal mine dust induced lung disease, both pneumoconiosis and related emphysema*, was too minimal to cause or contribute to any health problem or impairment.” Employer’s Brief at 23 (emphasis added). Although employer characterizes the miner’s pneumoconiosis and coal mine dust-induced emphysema as too mild to have contributed to any pulmonary impairment, employer essentially concedes the existence of both clinical pneumoconiosis and legal pneumoconiosis (emphysema due in part to coal mine dust exposure). We, therefore, affirm the administrative law judge’s findings that employer failed to disprove clinical pneumoconiosis or legal pneumoconiosis.

Employer contends that the administrative law judge erred in finding that employer failed to establish “that no part of the miner’s death was caused by pneumoconiosis.” In addressing the cause of the miner’s death, the administrative law judge accorded the greatest weight to the opinion of the miner’s treating physician, Dr. Smith, stating:

I find that Dr. Smith’s conclusion that the [m]iner’s coal mine dust induced lung disease contributed to his death is reasonable because it takes into account the [m]iner’s multiple medical problems and reasonably explains how lung disease contributed to the [m]iner’s death by increasing venous pressure and worsening the bleeding from the arteriovenous malformations. Thus, I afford controlling weight to Dr. Smith’s opinion that the [m]iner suffered from clinical and legal pneumoconiosis which contributed to his death.

Decision and Order at 32.

The administrative law judge further noted that, “[l]ike Dr. Smith, Dr. Houser opined that the miner suffered from clinical and legal pneumoconiosis and cor pulmonale and that his lung disease contributed to his death.” *Id.* The administrative law judge accorded “full weight” to Dr. Houser’s opinion, finding that the doctor’s “explanation of how the [m]iner’s limited respiratory reserve and increased venous pressure from cor pulmonale contributed to [his] death is well-reasoned and takes into account the [m]iner’s complex medical condition.” *Id.*

The administrative law judge afforded little weight to the opinions of Drs. Rosenberg and Hippensteel because their opinions were based upon “less extensive documentation.” *Id.* The administrative law judge found that, “[w]ithout the opportunity to consider the hypoxia, oxygen dependency, and evidence of resolution of the restrictive pericarditis, Dr. Rosenberg and Dr. Hippensteel are not able to persuasively rule out

pneumoconiosis and emphysema, or coal mine employment generally, as factors which contributed to the [m]iner's death."¹⁶ *Id.*

The administrative law judge also considered the autopsy reports of Dr. Lopes, the autopsy prosector, and Drs. Bush and Oesterling, reviewing pathologists. The administrative law judge found that the autopsy evidence does not assist employer in ruling out coal dust exposure as a cause of the miner's death:

Specifically, I find that [the autopsy opinions] confirm the presence of simple coal workers' pneumoconiosis, emphysema, and complex cardiac problems, as well as pulmonary hypertension[,] and do not adequately rule out the coal dust as a factor in the complex presentation on autopsy. I find that the pathologists did not have the benefit of considering a complete picture of the [m]iner's hospital course and, therefore, I give little weight to the opinions of Drs. Bush and Oesterling that coal mine dust exposure did not contribute to the [m]iner's death.

Decision and Order at 24. The administrative law judge, therefore, found that employer failed to rule out coal mine dust exposure as a cause of the miner's death. *Id.* at 33.

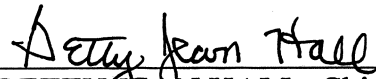
Employer generally asserts that the medical evidence is sufficient to rule out clinical and legal pneumoconiosis as a cause of the miner's death. Employer, however, alleges no specific error in regard to the administrative law judge's consideration of the evidence. *See Cox v. Benefits Review Board*, 791 F.2d 445, 9 BLR 2-46 (6th Cir. 1986); *Sarf v. Director, OWCP*, 10 BLR 1-119 (1987). Because the Board is not empowered to engage in a *de novo* proceeding or unrestricted review of a case brought before it, the Board must limit its review to contentions of error that are specifically raised by the parties. *See* 20 C.F.R. §§802.211, 802.301. The Board is not empowered to reweigh the evidence. *Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113 (1989). Consequently, we affirm the administrative law judge's finding that employer failed to establish that "no part of the miner's death was caused by pneumoconiosis as defined in §718.201." 20 C.F.R. §718.305(d)(2)(ii).


Because claimant invoked the Section 411(c)(4) presumption that the miner's death was due to pneumoconiosis, and employer did not rebut the presumption, the administrative law judge's award of benefits is affirmed.

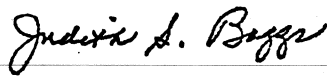
¹⁶ The miner's death certificate lists the cause of death as renal failure due to congestive heart failure and infective endocarditis. Director's Exhibit 13. Although the administrative law judge noted that the miner's death certificate does not mention pneumoconiosis, emphysema or COPD, she found that it was outweighed by the more thorough medical opinions of Drs. Smith and Houser. Decision and Order at 32.

Accordingly, the administrative law judge's Decision and Order awarding benefits is affirmed.

SO ORDERED.


BETTY JEAN HALL, Chief
Administrative Appeals Judge


REGINA C. McGRANERY
Administrative Appeals Judge


JUDITH S. BOGGS
Administrative Appeals Judge

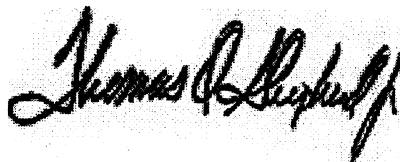
CERTIFICATE OF SERVICE

2014-0261-BLA Patricia F. Fitzwater (Widow of Jackie L. Fitzwater) v. Westmoreland Coal Comoany,
Director, Office of Workers' Compensation Programs (Case No. 10-BLA-5364)

I certify that the parties below were served this day.

APR 29 2015

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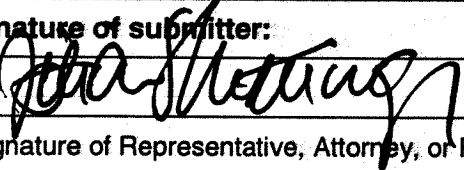
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UNITED STATES DEPARTMENT OF LABOR OFFICE OF ADMINISTRATIVE LAW JUDGES

BLACK LUNG BENEFITS ACT EVIDENCE SUMMARY FORM

Case Name:	Patricia Fitzwater, widow of Jackie Fitzwater v. Westmoreland Coal Company
Case No.:	2010-BLA-5364

Evidence submitted in support of position of: Claimant ☒ Employer Director (check one)

Signature of submitter:	Address of Submitter:		
<u>s/</u> 	Jackson Kelly PLLC P. O. Box 619 Morgantown, WV 26507		
^ Signature of Representative, Attorney, or Party			
William S. Mattingly			
^ Printed Name of Representative, Attorney, or Party	Phone:	304-284-4110	Fax: 304-284-4156

Date of this submission:	April 17, 2012
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I. Chest x-ray evidence

- A. Initial evidence.** A party may submit no more than two chest x-ray interpretations in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	B-Reader (B)/ Board Cert. (BCR)	Date of X-ray study	Date of Reading	Film Quality	Reading
EE 2	Francke	B,BCR	01/22/81	05/05/81		Negative
EE 2	Lapp	B	01/22/81	11/27/81		t; 0/1

OWCP Evaluation. The Department is required to provide the miner with a chest x-ray study as part of the complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented a rereading which “tends to undermine” a specific x-ray exhibit set forth above. In such a case, the proponent of the x-ray exhibit “shall be entitled to submit an additional statement from the physician who originally interpreted the chest x-ray.” 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which “tends to undermine” the findings of the Department-sponsored chest x-ray study.

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- C. Rebuttal evidence.** A party may offer no more than one physician's interpretation of each chest x-ray study submitted by opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	B-Reader (B)/ Board Cert. (BCR)	Date of X-ray study	Date of Reading	Film Quality	Reading

For rebuttal of Department-sponsored chest x-ray study only.

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II. Pulmonary function studies

- A. Initial evidence.** A party may submit the results of no more than two pulmonary function studies in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Study	Tracings present?	Flow-volume loop?	Broncho-dilator?	FEV1	FVC/MVV	Coop. and Comp. Noted?
EE 2	Daniel	10/24/79	Yes	No	No	3.03	3.92/120	No
EE 2	Egnor	01/22/81	Yes	No	No	3.19	4.21/154	No

OWCP Evaluation. The Department is required to provide the miner with a pulmonary function study as part to the complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which “tends to undermine” a specific pulmonary function study exhibit set forth above. In such a case, the proponent of the pulmonary function study exhibit “shall be entitled to submit an additional statement from the physician who administered the objective testing.” 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which “tends to undermine” the findings of the Department-sponsored pulmonary function study.

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- C. Rebuttal evidence.** A party may offer no more than one physician’s assessment of each pulmonary function study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

For rebuttal of Department-sponsored pulmonary function study only.

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III. Blood gas studies**A. Initial evidence.**

A party may submit the results of no more than two blood gas studies in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Comments
EE 2	Daniel	10/24/79	0-2999	R E	38 38	60 75	
EE 2	Egnor	01/22/81	0-2999	R E	38 37	63 82	

OWCP Evaluation. The Department may provide the miner with a blood gas study as part of the complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which "tends to undermine" a specific blood gas study set forth above. In such a case, the proponent of the blood gas study exhibit "shall be entitled to submit an additional statement from the physician who . . . administered the objective testing." 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored blood gas study.

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- C. Rebuttal evidence.** A party may offer no more than one physician's assessment of each blood gas study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

For rebuttal of Department-sponsored blood gas study only.

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IV. Medical records

The parties are notified that "medical records" may only be based on medical evidence which is admissible consistent with the evidentiary limitations at 20 C.F.R. § 725.414(a)(2)(i) and (3)(i), and (c) (2001). 20 C.F.R. §§ 725.414(a)(2)(i) and 725.457(d) (2001). Medical reports are defined in the regulations as:

A physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by the physician who examined the miner and/or reviewed the available admissible evidence. A physician's written assessment of a single objective test, such as a chest x-ray or a pulmonary function test, shall not be considered a medical report for purposes of this section. 20 C.F.R. § 725.414(a)(1) (2001).

A. Initial evidence. A party may submit no more than two medical reports in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Medical Report	Comments
EE 3	Rosenberg	04/14/10	<ol style="list-style-type: none"> 1. It can be stated with a reasonable degree of medical certainty that Mr. Fitzwater at worst had a minimal degree of clinical coal workers' pneumoconiosis. 2. This coal workers' pneumoconiosis was not associated with any respiratory impairment and/or disability. 3. His death was not caused, hastened or accelerated by past coal dust exposure and the presence of coal workers' pneumoconiosis. 4. He died primarily from congestive heart failure and renal failure both of which were unrelated to past coal mine dust exposure.
EE 4	Hippensteel	05/24/10	<ol style="list-style-type: none"> 1. Mr. Fitzwater did not have evidence of clinical coal workers' pneumoconiosis in life even though it was mentioned as a historical diagnosis in the medical records. 2. The finding of minimal simple coal workers' pneumoconiosis at autopsy is the most sensitive and specific test for the presence or absence of pneumoconiosis and trumps the lack of objective evidence of such a disease in life. Minimal pneumoconiosis, however, rarely cause cor pulmonale in any individual and I think the evidence in this case is against it causing any clinically significant lung impairment or thereby any secondary negative effect on his heart function. 3. This man had multiple severe diseases unrelated to his coal mine dust exposure. These diseases in combination were the whole cause of his death. 4. He did not have objective findings to suggest that he had any effects from his minimal simple coal workers' pneumoconiosis that caused, hastened or contributed to his death. 5. It can be stated with a reasonable degree of

			medical certainty that this man would have died at the same time and in the same manner had he never contracted coal workers' pneumoconiosis from coal dust exposure.
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OWCP Evaluation. The Department is required to provide the miner with a complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

DE			
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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented "rebuttal evidence" which "tends to undermine" the conclusion of a physician who prepared one of the above-listed medical reports. It is noted that "rebuttal evidence" may consist of "no more than one physician's interpretation of each chest X-ray, pulmonary function test, blood gas study, autopsy or biopsy" submitted by the opposing party. In such a case, the proponent is entitled to submit an "additional statement" from the physician who prepared the medical report explaining his or her conclusion in light of the rebuttal evidence. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored medical opinion.

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V. Autopsy evidence

- A. Initial evidence.** A party may submit no more than one autopsy report in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Autopsy Report	Comments
DE 17	Oesterling	07/28/09	<ol style="list-style-type: none"> 1. There is evidence of minimal anthracotic pigmentation within this man's pleura with a perivascular and peribronchiolar cuffing. 2. This level of dust deposition would not alter pulmonary function. 3. Without alterations in pulmonary function the dust should not have produced respiratory symptomatology. 4. Without alterations in structure the dust would not have hastened, contributed to or caused his demise. 5. It is my opinion with a reasonable degree of medical certainty that coal dust was not a factor

			in any way in the death of this man. His lung disease was primarily related to his cardiac disease which is unrelated to coal mine dust. His death certificate makes no mention of coal workers' pneumoconiosis.
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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which "tends to undermine" the autopsy report. In such a case, the proponent of the report shall be entitled to submit an "additional statement" from the physician who prepared the autopsy report explaining his or her conclusions in light of the rebuttal evidence. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

- C. Rebuttal evidence.** A party may offer no more than one physician's interpretation of the opposing party's autopsy report. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Report Dated:	Comments
EE 1	Bush	08/27/09	09/25/08	<p>1. The lungs show evidence of a minimal degree of simple coal workers' pneumoconiosis.</p> <p>2. The minimal degree of simple coal workers' pneumoconiosis did not contribute to the death of Mr. Fitzwater. The degree and extent of coal dust disease is far too limited to have any contribution to the events leading to the death of this miner.</p> <p>3. The changes observed in the lungs include mild emphysema which may have caused some degree of respiratory impairment prior to death.</p> <p>4. He was totally disabled prior to death as a result of massive blood loss, septicemia, renal failure, and possibly infected aortic valve prosthesis. In addition, the sections of the heart reveal a recent myocardial infarction with early healing changes suggesting the infarct occurred some weeks before death.</p> <p>5. Coal workers' pneumoconiosis or occupational exposure to coal dust did not contribute to respiratory impairment or disability in Mr. Fitzwater.</p> <p>6. Coal workers' pneumoconiosis or coal dust exposure played no role in nor hastened the death of Mr.</p>

				Fitzwater.
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VI. Biopsy evidence

- A. Initial evidence.** A party may submit no more than one report of each biopsy in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Biopsy Report	Comments

- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which “tends to undermine” a particular biopsy report. In such a case, the proponent of the report shall be entitled to submit an “additional statement” from the physician who prepared the biopsy report explaining his or her conclusions in light of the rebuttal evidence. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

- C. Rebuttal evidence.** A party may offer no more than one physician's interpretation of each biopsy report submitted by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Report Dated:	Comments

VII. “Other medical evidence” under § 718.107

- A. Initial evidence.** A party may submit “other medical evidence” under § 718.107, such as CT-scans, and “[t]he party submitting the test or procedure . . . bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits.” 20 C.F.R. § 718.107(b) (2001).

Exhibit No.	Physician	Type of Record	Date of Activity	Comments
DE 16	Skelton	CT-Scan	09/04/08	CT Chest, abdomen and pelvis without contrast: moderately sized layering right pleural effusion with associated atelectasis is noted. The lungs are otherwise clear. No focal consolidation. No pneumothorax. No pleural thickening. Cardiomegaly is noted.

- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which “tends to undermine” a specific test or study set forth above. In such a case, the proponent of the study or test “shall be entitled to submit an additional statement from the physician who . . . administered the objective testing.” 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

C. Rebuttal evidence. A party may offer no more than one physician's assessment of each test or study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

VIII. Hospitalization records and treatment notes

The amended regulations provided that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease may be received into evidence." 20 C.F.R. § 725.414(a)(4) (2001).

Exhibit No.	Beginning and Ending Dates of Hospitalization/Treatment	Name of Hospital/Physician	Nature of Treatment
DE 16	11/30/98-12/06/98	Spotnitz/UVA	1. Aortic valve replacement with 25 mm mechanical St. Jude valve.
DE 16	01/26/99	Haines/UVA	1. Procedure: electrical cardioversion. A single 200 joule synchronized transthoracic shock was administered with restoration to normal sinus rhythm. The patient woke without difficulty and was discharged home.
DE 16	10/21/99	Gimple/UVA	1. Patient was transferred from Greenbrier Valley Medical Center for cardiac catheterization. 2. He was admitted to Greenbrier Valley Medical Center on 10/11/99 with a several month history of increasing shortness of breath, a recurrent right pleural effusion and increasing right lower extremity edema. The patient had a right thoracentesis which reportedly came back as a transudate. The chest x-ray was consistent with congestive heart failure.
DE 16	12/20/00 -12/26/00	Kron/UVA	1. Pericardiectomy 2. Constrictive pericarditis 3. Diabetes 4. Hypertension 5. Chronic obstructive pulmonary disease 6. Hypothyroidism 7. Obstructive sleep apnea 8. Paroxysmal atrial fibrillation

DE 16	05/30/02	Powers/UVA	<ol style="list-style-type: none"> 1. Group A Strep toxic shock syndrome 2. Renal failure 3. Gastrointestinal bleed 4. Left lower extremity cellulitis 5. Atrial fibrillation 6. Status post St. Jude's aortic valve replacement 7. Chronic obstructive pulmonary disease 8. Diabetes mellitus 9. Hypothyroidism 10. Hypertension
DE 16	07/12/03	Ragosta/UVA	<ol style="list-style-type: none"> 1. Congestive heart failure 2. Chronic obstructive pulmonary disease. 3. Obstructive sleep apnea. 4. Gout 5. BPH 6. Hypothyroidism
DE 16	02/26/04	Ragosta/UVA	<ol style="list-style-type: none"> 1. Congestive heart failure 2. Severe aortic stenosis status post aortic valve repair. 3. History of constrictive pericarditis. 4. Atrial fibrillation 5. Hypertension 6. Chronic obstructive pulmonary disease. 7. Sleep apnea 8. Diabetes mellitus 9. Iron deficiency anemia
DE 16	08/09/08-08/24/08	University of Virginia	<ol style="list-style-type: none"> 1. Anticoagulation for atrial fibrillation and aortic valve replacement 2. Gastrointestinal bleed status post AVM ablation developed acute stroke today. 3. Congestive heart failure exacerbation 4. Positive tobacco use quit one year ago 5. Mechanic aortic valve infective endocarditis 6. Spontaneous bacterial peritonitis. 7. Arteriovenous malformations of the intestines 8. Stroke 9. Atrial fibrillation 10. Altered mental status 11. Acute kidney injury 12. Left subclavian deep vein thrombosis.
DE 16	09/01/08-09/24/08	University of Virginia	<ol style="list-style-type: none"> 1. Acute on chronic kidney disease. 2. Endocarditis 3. Hypertension 4. Acidosis 5. Hyperphosphatemia 6. Anemia 7. Patient has a 80 pack year smoking history quitting one year ago
DE 16	09/24/08	Lin/UVA	<ol style="list-style-type: none"> 1. Gi bleed 2. Chronic renal failure with progression to end-stage renal disease.

			3. Cirrhosis 4. Urinary tract infection 5. Spontaneous bacterial peritonitis 6. Infective endocarditis
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IX. Testimony, 20 C.F.R. § 725.414(c).

A physician who prepared a medical report, admitted under § 725.414, above, may testify with respect to the claim. If a party submitted fewer than two medical reports, a physician who did not prepare a prior medical report may testify in lieu of such a medical report, but the testimony is considered a medical report of the party.

Deposition Exhibit No.	Physician Name	Date of Testimony/deposition	Exhibit No. of Earlier Report	Date of Earlier Report	Comments
EE 6	Hippensteel	03/30/12	EE 4	05/24/10	
EE 7	Rosenberg	04/09/12	EE 3	04/14/10	

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing was served upon the following by United States mail, postage prepaid, or other delivery service as indicated, this 17th day of April, 2012.

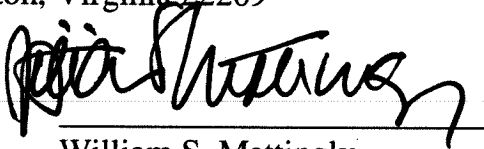
HAND DELIVERY:

Honorable Lystra A. Harris
Office of Administrative Law Judges
United States Department of Labor
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

Timothy C. MacDonnell
Legal Practice Clinic
Attention: Sheryl Salm, Room 106
Washington & Lee University School of Law, Lewis Hall
Lexington, VA 24450

REGULAR:

Douglas N. White
U.S. Department of Labor
Office of the Regional Solicitor
1100 Wilson Boulevard
22nd Floor West
Arlington, Virginia 22209



William S. Mattingly

cc: Wells Fargo Disability Management
M0793117.DOC\WSMtk




**UNITED STATES DEPARTMENT OF LABOR
OFFICE OF ADMINISTRATIVE LAW JUDGES**

**BLACK LUNG BENEFITS ACT
EVIDENCE SUMMARY FORM**

Case Name:	Patricia A. Fitzwater, surviving spouse of Jackie L. Fitzwater v. Westmoreland Coal Co. and Director, OWCP.
Case No.:	Case No. 2008-BLA- 5364

Evidence submitted in support of position of: **X Claimant** Employer Director (check one)

Signature of submitter:		Address of Submitter:			
		Lewis Hall Room 106 Washington and Lee University Lexington, VA 24450			
Signature of Representative, Attorney, or Party					
Timothy C. MacDonnell					
Printed Name of Representative, Attorney, or Party		Phone:	540-458-8562	Fax:	540-458-8135

Date of this submission:	March 28, 2012
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I. Chest x-ray evidence

- A. Initial evidence.** A party may submit no more than two chest x-ray *interpretations* in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	B-Reader (B)/ Board Cert. (BCR)	Date of X-ray study	Date of Reading	Film Quality	Reading

OWCP Evaluation. The Department is required to provide the miner with a chest x-ray study as part of the complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented a rereading which "tends to undermine" a specific x-ray exhibit set forth above. In such a case, the proponent of the x-ray exhibit shall be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored chest x-ray study.

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- C. Rebuttal evidence.** A party may offer no more than one physician's interpretation of *each chest x-ray study* submitted by opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	B-Reader (B)/ Board Cert. (BCR)	Date of X-ray study	Date of Reading	Film Quality	Reading

For rebuttal of Department-sponsored chest x-ray study only.

II. Pulmonary function studies

- CX. Initial evidence.** A party may submit the results of no more than two pulmonary function studies in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of study	Tracings present?	Flow- volume loop?	Broncho- dilator?	FEV1	FEV1/ FVC	Coop. and Comp. Noted?

OWCP Evaluation. The Department is required to provide the miner with a pulmonary function study as part of the complete pulmonary evaluation. 20 C.F.R. § 725.406(a)(2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which "tends to undermine" a specific pulmonary function study exhibit set forth above. In such a case, the proponent of the pulmonary function study exhibit shall be entitled to submit an additional statement from the physician who . . . administered the objective testing. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored pulmonary function study.

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- C. Rebuttal evidence.** A party may offer no more than one physician's assessment of each pulmonary function study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

For rebuttal of Department-sponsored pulmonary function study only.

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III. Blood gas studies

CX. Initial evidence.

A party may submit the results of no more than two blood gas studies in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Study	Altitude	Resting Exercise(E)	PCO2	PO2	Comments

OWCP Evaluation. The Department may provide the miner with a blood gas study as part of the complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which "tends to undermine" a specific blood gas study set forth above. In such a case, the proponent of the blood gas study exhibit shall be entitled to submit an additional statement from the physician who . . . administered the objective testing. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored blood gas study.

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- C. Rebuttal evidence.** A party may offer no more than one physician's assessment of each blood gas study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

For rebuttal of Department-sponsored blood gas study only.

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IV. Medical reports

The parties are notified that medical reports may only be based on medical evidence which is admissible consistent with the evidentiary limitations at 20 C.F.R. § 725.414(a)(2)(i), (3)(i), and (c) (2001). 20 C.F.R. §§ 725.414(a)(2)(i) and 725.457(d) (2001). Medical reports are defined in the regulations as:

A physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by the physician who examined the miner and/or reviewed the available admissible evidence. A physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, shall not be considered a medical report for purposes of this section.

20 C.F.R. § 725.414(a)(1) (2001).

- CX. Initial evidence.** A party may submit no more than two medical reports in support of its position. 20 C.F.R. § 725.414(a)(2)(i) and (3)(i) (2001).

Exhibit No.	Physician	Date of Medical Report	Comments
CX-2 (DX-18)	Dr. Lynn N. Smith	December 31, 2008	<p><u>Conclusion</u></p> <p>"I have been Mr. Fitzwater's primary care attending over the past 20 years. Mr. Fitzwater recently died of complications of his underlying lung disease. Autopsy reports, which are included, document the presence of his underlying pneumoconiosis."</p> <p>"It is believed that this gentleman died as a direct consequence of his underlying lung disease and the complications that it caused. The autopsy is subsequent proof of this gentleman to underlying pneumoconiosis."</p>
CX-4	Dr. William C. Houser	February 15, 2012	<p><u>Conclusion</u></p> <p>"In summary, I believe Mr. Fitzwater had clinical pneumoconiosis (on the basis of his 40-year history of coal mine employment and pathology findings), and legal pneumoconiosis (emphysema). I believe cigarette smoking is a contributing factor to the development of his emphysema. I believe the combination of clinical and legal pneumoconiosis caused the hypoxemia, pulmonary hypertension, and cor pulmonale. I believe the elevated venous pressure secondary to right ventricular failure associated with cor pulmonale was a significant factor in the bleeding from the arterial venous malformations in the gastrointestinal tract. I believe the clinical and legal pneumoconiosis contributed to his death as a result of increased work of breathing and diminished respiratory reserve. All of these factors added an additional burden to his cardiovascular system and diminished his ability to survive other insults."</p>

OWCP Evaluation. The Department is required to provide the miner with a complete pulmonary evaluation. 20 C.F.R. § 725.406(a) (2001).

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- B. Rehabilitative evidence** is permitted ONLY if opposing party has presented rebuttal evidence which "tends to undermine" the conclusion of a physician who prepared one of the above-listed medical reports. It is noted that rebuttal evidence may consist of no more than one physician's interpretation of each chest X-ray, pulmonary function test, blood gas study, autopsy or biopsy submitted by the opposing party. In such a case, the proponent is entitled to submit an additional statement from the physician who prepared the medical report explaining his or her conclusion in light of the rebuttal evidence. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments
CX-9	Dr. Lynn N. Smith		CX-2 (DX-18)	Report Forthcoming
CX-10	Dr. William C. Houser		CX-4	Report Forthcoming

For use by the Director only. The Director may submit rehabilitative evidence if any party submits evidence which "tends to undermine" the findings of the Department-sponsored medical opinion.

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V. Autopsy evidence

Exhibit No.	Physician	Date of Medical Report	Comments
CX-8 (DX-15)	Dr. M. Beatriz Lopes	09/25/2008	<p>Final Pathologic Diagnosis:</p> <ol style="list-style-type: none"> 1. Simple Coal Worker's Pneumoconiosis 2. Cardiomegaly with Ischemic Cardiomyopathy 3. Atherosclerosis 4. Status Post Aortic Valve Replacement and Pacer Placement <p>GROSS DESCRIPTION: Respiratory System—The lungs and trachea weight 1650 gm and show normal lobation. The pleural surface is fibrous and is adhered to the chest wall. Cut sections reveal red-brown parenchyma which is remarkable for diffuse emphysema. Pulmonary arteries are free of thromboemboli. The bronchial tree is unremarkable.</p> <p>Microscopic Descriptions (5 H&E): Lungs: Sections of the lungs demonstrate diffuse emphysematous changes. There are multifocal areas of anthracotic nodules.</p> <p>Case Discussion: The gross and histologic findings in this case are consistent with SCWP. The pathologic features of SCWP</p>

Exhibit No.	Physician	Date of Medical Report	Comments
			include the presence of dust macules and focal emphysema, both of which are required for diagnoses. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules.

VI. Biopsy evidence – NONE

VII. Other medical evidence under § 718.107 -- NONE

- CX. **Initial evidence.** A party may submit other medical evidence under § 718.107, such as CT-scans, and [t]he party submitting the test or procedure . . . bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits. 20 C.F.R. § 718.107(b) (2001).

Exhibit No.	Physician	Type of Record	Date of Activity	Comments

- B. **Rehabilitative evidence** is permitted ONLY if opposing party has presented evidence which "tends to undermine" a specific test or study set forth above. In such a case, the proponent of the study or test shall be entitled to submit an additional statement from the physician who . . . administered the objective testing. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rehabilitation of Exhibit No.	Comments

- C. Rebuttal evidence.** A party may offer no more than one physician's assessment of each test or study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii) (2001).

Exhibit No.	Physician	Date of Report	Rebuttal of Exhibit No.	Comments

VIII. Hospitalization records and treatment notes

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease may be received into evidence. 20 C.F.R. § 725.414(a)(4) (2001).

Exhibit No.	Beginning and Ending Dates of Hospitalization/Treatment	Name of Hospital/Physician	Nature of Treatment
CX-1	1983 to September 24, 2008	Dr. Lynn N. Smith	Physician's Treatment File over (twenty-five years) as it relating to (1) lung disease; (2) cor pulmonale; and (3) gastrointestinal bleeding. The file includes, but is not limited to: <ul style="list-style-type: none"> • Hospitalization Summaries; • Office Notes • Objective Test Results: x-ray, ABG, PFT, and Echocardiograms; and • Laboratory Results emphasizing Coumadin levels and dosage
CX-6 (DX-16)	The file contains the following hospitalizations: <ul style="list-style-type: none"> • 11/30/1998--12/05/2008 • 12/11/2000--12/24/2000 • 05/14/2002--05/30/2002 • 07/08/2003--07/12/2003 • 02/18/2004--02/26/2004 • 08/01/2008--08/24/2008 • 08/24/2008--09/24/2008 	University of Virginia Hospital	Treatment record from numerous hospitalizations at the University of Virginia Hospital. This file includes the death summary dated September 24, 2008. The file has independent diagnoses of COPD, pneumoconiosis and normal left-sided heart function. These notes detail Mr. Fitzwater's cardiac cauterizations. Mr. Fitzwater's hospitalizations span from 1998 to 2008. The file includes radiographic interpretations, objective test results and notes, physicians' notes, and discharge summaries.
CX-7 (DX-13)	September 24, 2008	Dr. K. Molly McShane	Death Certificate issued September 29, 2008

IX. Testimony. C.F.R. § 725.414(c).

A physician who prepared a medical report, admitted under § 725.414, above, may testify with respect to the claim. If a party submitted fewer than two medical reports, a physician who did not prepare a medical report may testify in lieu of such a medical report, but the testimony is considered a medical report of the party. 20 C.F.R. § 725.457(c)(2).

Exhibit No.	Testimony	Name of Hospital/Physician	Nature of Treatment
CX-3	Deposition Transcript dated February 29, 2012	Dr. Lynn N. Smith	Reasoned Medical Opinion
CX-5	Deposition Transcript dated March 22, 2012	Dr. William Houser	Reasoned Medical Opinion

Survivor's Form For Benefits Under
The Black Lung Benefits Act

U. S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

If you are a survivor of a person who was receiving Federal black lung benefits resulting from a claim filed before 1982, this form is a Survivor's Notification of the Beneficiary's Death. Otherwise, this is a claim for survivor's benefits. This form is authorized by the Black Lung Benefits Act (30 U.S.C. 901, et seq.) and by 20 C.F.R. 410.221 and 20 C.F.R. 725.304. This information will be used to determine possible eligibility for and the amount of benefits payable under the Act. Benefits may be payable to you, your children and all children of the deceased miner. The information on this form is required to obtain a benefit. However, disclosure of your or the deceased miner's Social Security Number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

OMB No: 1215-0069

Expires: 08/31/2009

(For Agency Use Only)

SA-OWCP-DC (Rev. 11-90)
JOHNSTOWN PA 15901

JAN 1 2009

1. Deceased Coal Miner's Name: First Jackie Middle Lee Last Fitzwater

2. Deceased Coal Miner's Social Security Number: 236-56-5934

3. COAL MINER'S BIRTH AND DEATH DATES (ATTACH DEATH CERTIFICATE IF AVAILABLE)

Date of Birth:

4-25-36

Date of Death:

9-24-08

Autopsy?

Yes

No

4. Your Name: First Patricia Middle Ann Last Fitzwater

5. Your Social Security Number: 234-56-1272

6. Your Date of Birth

02-04-36

7. SHOW YOUR RELATIONSHIP TO THE MINER

☒ Surviving Spouse (wife or husband)☐ Dependent Child☐ Surviving Divorced Spouse☐ Dependent Parent, Brother or Sister

8. Have you or the miner ever filed a State or Federal workers' compensation claim for death or disability due to coal workers' pneumoconiosis (Black Lung) or any other lung conditions?

Yes

✓

No

9. Have you or any dependent of the miner ever received Federal Black Lung Benefits under another miner's Social Security number?

Yes

✓

No

*** IF YOU ARE FILING AS A CHILD, PARENT, BROTHER OR SISTER, GO TO QUESTION 12 ***

10. Do you or the miner have any dependent children under age 18; age 18 to age 23 and attending school; age 18 or older and disabled?

Yes

No ✓

11. Were you or the miner ever married to anyone else at any time?

Yes

No ✓

12. Do you authorize any physician, hospital, agency or other organization (including the Social Security Administration) to disclose to the U.S. Department of Labor any medical records or other information important to your claim?

Yes

✓

No

13. The following events may affect your entitlement to Federal Black Lung Benefits. Do you agree to notify the U.S. Department of Labor promptly if any of the events listed below occur?

Yes

✓

No

- You become entitled to receive any workers' compensation or occupational disease payments because of the miner's disability or death due to pneumoconiosis (Black Lung Disease).
- A person receiving benefits marries, dies, or is adopted by someone else, becomes disabled or the existing disability ceases, or if divorced, receives support payments from previous spouse.
- A child (age 18-23) stops attending school, or in the case of a disabled child (age 18 or over), the disabling condition improves.

(PLEASE COMPLETE THE OTHER SIDE OF THIS FORM)

Form CM - 912
Rev. Oct. 1998Director's Exb. No. 2
App. 000212
Consisting of 4 pages.

PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974 (5 U.S.C. 552a), as amended, you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to this application, on claimants and their immediate families; (2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of the claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim; (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, other than the SSN or TIN, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

COMPUTER MATCHING PROGRAM. The Department of Labor conducts computer matches with the Social Security Administration. Any information provided by applicants or recipients of financial assistance or payments under Federal benefit programs may be subject to verification through computer matches which the Department of Labor conducts with the Social Security Administration

DEPARTMENT OF LABOR
ESA-OW CP-DCMWS
JOHNSTOWN PA 15901

JAN 14 2009

SIGNATURE OF APPLICANT

I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than \$1,000.00, or by imprisonment for not more than one year, or both.

Signature in ink (First, Middle, Last) <i>Patricia Ann Fibervater</i>	Date <i>12-8-08</i>
Living Address (Number, Street, Apt. No., PO Box) <i>PO Box 312</i>	County you live in <i>Greenbrier</i>
City, State, Zip Code <i>Quinwood W. Va 25981</i>	Area Code and Telephone Number <i>304-438-6633</i>

Witnesses are required only if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full address.

Signature of Witness	Signature of Witness
Address of Witness	Address of Witness
City, State, Zip Code	City, State, Zip Code

Public reporting for this collection of information is estimated to average 8 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, NW, Room C-3520, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

COMMONWEALTH OF VIRGINIA - CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS - RICHMOND

COPY A

FOR DIVISION OF
VITAL RECORDSREGISTRATION
AREA NUMBER 203CERTIFICATE
NUMBER 1013STATE FILE
NUMBER

DECEDENT	1. FULL NAME OF DECEDENT (first, middle, last) Jackie Lee Fitzwater						2. SEX male <input checked="" type="checkbox"/> female <input type="checkbox"/>	
	3. DATE OF DEATH (mo., day, year) 09/24/2008		4. AGE 72 years		IF UNDER 1 YEAR months days		IF UNDER 1 DAY hours minutes	
PLACE OF DEATH	7. NAME OF HOSPITAL OR INSTITUTION OF DEATH (if none, so state) UNIVERSITY OF VIRGINIA						8. COUNTY OF DEATH (if independent city, leave blank)	
	9. CITY OR TOWN OF DEATH CHARLOTTESVILLE						10. STREET ADDRESS OR RT. NO. OF PLACE OF DEATH 1215 LEE ST	
USUAL RESIDENCE OF DECEDENT	11. STATE (OR FOREIGN COUNTRY) OF DECEDENT'S RESIDENCE WEST VIRGINIA						12. COUNTY OF DECEDENT'S RESIDENCE (if independent city, leave blank) GREENBRIER	
	13. CITY OR TOWN OF RESIDENCE QUINWOOD						14. STREET ADDRESS OR RT. NO. OF RESIDENCE LESLIE BENCH RD	
PERSONAL DATA OF DECEDENT	15. NAME OF DECEDENT'S FATHER MAHONE B. FITZWATER						16. MAIDEN NAME OF DECEDENT'S MOTHER GLENDA MAE SKIDMORE	
	17. RACE OF DECEDENT WHITE		18. OF HISPANIC ORIGIN? If yes, specify Cuban, Mexican, Puerto Rican, etc. <input checked="" type="checkbox"/> no <input type="checkbox"/> yes		19. EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5 +)			
	20. CITIZEN OF WHAT COUNTRY USA		21. BIRTHPLACE (state or country) WEST VIRGINIA		22. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		23. IF MARRIED OR WIDOWED, NAME OF SPOUSE (if divorced leave blank) PATRICIA BLEVINS FITZWATER	
	24. SOCIAL SECURITY NUMBER 236-56-5934		25. USUAL OR LAST OCCUPATION MINER		26. KIND OF BUSINESS OR INDUSTRY COAL MINING		27. INFORMANT - OR SOURCE OF INFORMATION - RELATIONSHIP PATRICIA FITZWATER-WIFE	
CAUSE OF DEATH	28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → (A) renal failure (B) congestive heart failure (C) infective endocarditis						INTERVAL BETWEEN ONSET AND DEATH	
	28a. AUTOPSY? AUTHORIZED BY: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no							
TO PHYSICIAN: Complete and sign medical certification (item 28) and return both copies to funeral director as soon as possible after determination of cause.	28b. IF FEMALE, WAS THERE A PREGNANCY IN PAST 3 MONTHS? yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/>						28c. IF EXTERNAL CAUSE, IT WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH	
	28d. DESCRIBE HOW INJURY RELATING TO DEATH OCCURRED							
NOTE: If "Pending" must be indicated, so state in part 1 and notify registrar of final decision as soon as possible.	28e. TIME OF INJURY (mo., day, year) A.M.		28f. INJURY OCCURRED while at work <input type="checkbox"/> not while at work <input type="checkbox"/>		28g. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		28h. (city or town) (county) (state)	
	28i. To the best of my knowledge, death occurred at 11:05 (a.m.) (p.m.) on the date and place and from the cause(s) stated.							
MEDICAL CERTIFICATION	ACTUAL SIGNATURE K. Molly McShane NAME OF ATTENDING PHYSICIAN (Type or Print) K. Molly McShane						DATE SIGNED: 9/24/2008 ADDRESS OF ATTENDING PHYSICIAN Charlottesville, VA	
FUNERAL DIRECTOR	29. BURIAL <input checked="" type="checkbox"/> REMOVAL <input type="checkbox"/> CREMATION <input type="checkbox"/>		30. PLACE OF BURIAL, REMOVAL, ETC. (name of cemetery or crematory) (city or county) (state) Wallace Memorial Cemetery, Clintonville, WV					
	31. (Signature of funeral director or person legally filing this certificate) Wallace and Wallace, Inc.						NAME OF FUNERAL HOME AND ADDRESS: 213 Main St., Rainelle WV 25962	
REGISTRAR	32. (signature of registrar) Heather Makey						DATE RECORD FILED: September 29, 2008	
	RESERVED FOR REGISTRAR'S USE							

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT REPRODUCTION OF THE ORIGINAL RECORD FILED WITH THE ALBEMARLE-CHARLOTTESVILLE DEPARTMENT OF HEALTH, CHARLOTTESVILLE, VIRGINIA.

DATE ISSUED Sept 29 2008

Heather Makey
DEPUTY REGISTRAR

SEAL

ANY REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY STATUTE. DO NOT ACCEPT UNLESS IT BEARS THE IMPRESSED SEAL OF THE ALBEMARLE-CHARLOTTESVILLE DEPARTMENT OF HEALTH CLEARLY AFFIXED.

SECTION 32, 1-272, CODE OF VIRGINIA, AS AMENDED

Director's Exb. No. 13
Relating to 1 NARS.

**DEPARTMENT OF PATHOLOGY**

BOX 800-214, CHARLOTTESVILLE, VA 22908

(434) 924-9183 FAX: (434) 982-6519

Autopsy #: A08-149**Name:** FITZWATER, JACKIE LEE**History Number:** 1204422**Age:** 72 **Sex:** M **Race:** Caucasian**Admitted on:** 8/1/2008 00:00**Expired on:** 9/24/2008 11:05**Autopsy on:** 9/25/2008 09:32**AUTOPSY FINAL REVIEW REPORT****Service:****Physician:** Christine Lin, M.D.**Copy to:** Lawrence W. Gimple, M.D.

Fax finals to:

Amy Harris(GI)@3-6405 -> Vanessa Lee

Elaine Day (ID)@4-0075-> Amy Althoff

Anita Jacobson(Neph)@4-5848 -> Serge Joffy

Lynn Smith, MD

Rt 2 Box 171 Lewisburg, WV 24901

304-645-3207

Authorized By: Patricia Fitzwater**Relationship to Patient:** Wife**Autopsy Restrictions:** Chest Only

No restrictions for tissue disposition

Clinical History/Diagnosis:

The decedent is a 72 year old male with a past medical history of aortic stenosis secondary to a bicuspid aortic valve s/p aortic valve replacement, sleep apnea, type II diabetes, hypertension, chronic atrial fibrillation (s/p pacemaker for tachy-brady syndrome), chronic renal failure, coal miner's pneumoconiosis who presented to UVA on 8/2 for recurrent GI bleed secondary to multiple AVMs. The decedent stated that he has had approximately 96 transfusions in the last two years secondary to GI bleeding. The decedent was transfused and was doing well until the 9th of August, when he became dysarthric and had right sided weakness and was found to have a left thalamic stroke. On the 11th, he became febrile, with blood cultures growing out coagulase negative staph. On August 14th, he was found to have a thrombus in his left atrial appendage as well as a mass consistent with vegetation on his prosthetic aortic valve. Over the next several weeks, the decedent developed spontaneous bacterial peritonitis and worsening renal failure that required dialysis. On the 20th of September, his family made him comfort care and he passed away on the 24th of September.

Final Pathologic Diagnosis

SIMPLE COAL WORKER'S PNEUMOCONIOSES

-DIFFUSE PULMONARY EMPHYSEMA

-ANTHRACOTIC NODULES

-MILD PULMONARY HYPERTENSIVE CHANGES

CARDIOMEGALY WITH ISCHEMIC CARDIOMYOPATHY

-BIATRIAL DILATATION

-RIGHT VENTRICULAR DILATATION

- LEFT VENTRICULAR HYPERTROPHY
- MULTIFOCAL SUBACUTE AND REMOTE INFARCTS (MICROSCOPIC)

ATHEROSCLEROSIS

- AORTA: GRADE VII / VII
- CORONARY ARTERIES: 40% MAX OCCLUSION WITH CALCIFICATION

STATUS POST AORTIC VALVE REPLACEMENT AND PACER PLACEMENT

- LEFT CHRONIC FIBROTIC PLEURITIS AND CHRONIC FIBROTIC PERICARDITIS

Electronically Signed Out By M. Beatriz Lopes, M.D. on 10/29/2008
kms/10/6/2008

M. Beatriz Lopes, M.D.
Kristen M. Stashek, MD
Simone M. Dustin, M.D.
Vickie Y. Jo, M.D.



University of Virginia
HEALTH SYSTEM

DEPARTMENT OF PATHOLOGY

BOX 800-214, CHARLOTTESVILLE, VA 22908

(434) 924-9183 FAX: (434) 982-6519

Autopsy #: A08-149

Name: FITZWATER, JACKIE LEE

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Age: 72 Sex: M Race: Caucasian

Admitted on: 8/1/2008 00:00

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Autopsy on: 9/25/2008 09:32

AUTOPSY FINAL REPORT

Service:

Physician: Christine Lin, M.D.

Copy to: Lawrence W. Gimple, M.D.

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Lynn Smith, MD

Rt 2 Box 171 Lewisburg, WV 24901

304-645-3207

DEPARTMENT OF LABOR
ESA-OWCP-DCMWC
JOHNSTOWN PA 15901

MAR 04 2009

Authorized By: Patricia Fitzwater

Relationship to Patient: Wife

Autopsy Restrictions: Chest Only

No restrictions for tissue disposition

Clinical History/Diagnosis:

The decedent is a 72 year old male with a past medical history of aortic stenosis secondary to a bicuspid aortic valve s/p aortic valve replacement, sleep apnea, type II diabetes, hypertension, chronic atrial fibrillation (s/p pacer for tachy-brady syndrome), chronic renal failure, coal miner's pneumoconioses who presented to UVA on 8/2 for recurrent GI bleed secondary to multiple AVMs. The decedent stated that he has had approximately 96 transfusions in the last two years secondary to GI bleeding. The decedent was transfused and was doing well until the 9th of August, when he became dysarthric and had right sided weakness and was found to have a left thalamic stroke. On the 11th, he became febrile, with blood cultures growing out coag negative staph. On August 14th, he was found to have a thrombus in his left atrial appendage as well as a mass consistent with vegetation on his prosthetic aortic valve. Over the next several weeks, the decedent developed spontaneous bacterial peritonitis and worsening renal failure that required dialysis. On the 20th of September, his family made him comfort care and he passed away on the 24th of September.

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SIMPLE COAL WORKER'S PNEUMOCONIOSES

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CARDIOMEGALY WITH ISCHEMIC CARDIOMYOPATHY

-BIATRIAL DILATATION

-RIGHT VENTRICULAR DILATATION

DEPARTMENT OF LABOR
ESA-OWCP-DCMWC
JOHNSTOWN PA 15901

FEB 23 2009

FITZWATER, JACKIE LEE

Director's Exh. No. 15
Consisting of 3 pages.

- LEFT VENTRICULAR HYPERTROPHY
- MULTIFOCAL SUBACUTE AND REMOTE INFARCTS (MICROSCOPIC)

ATHEROSCLEROSIS

- AORTA: GRADE VII / VII
- CORONARY ARTERIES: 40% MAX OCCLUSION WITH CALCIFICATION

STATUS POST AORTIC VALVE REPLACEMENT AND PACER PLACEMENT

- LEFT CHRONIC FIBROTIC PLEURITIS AND CHRONIC FIBROTIC PERICARDITIS

Electronically Signed Out By M. Beatriz Lopes, M.D. on 10/29/2008

By my electronic signature affixed below, I affirm that I have reviewed this report and all pathologic materials & information pertaining to this case with the resident/fellow physicians listed, and that I am personally responsible for all stated diagnoses in this report.

kms/10/6/2008

M. Beatriz Lopes, M.D.
Kristen M. Stashek, MD
Simone M. Dustin, M.D.
Vickie Y. Jo, M.D.

Gross Description

EXTERNAL EXAMINATION: The decedent, received in a white body bag, is a well developed, well-nourished, adult Caucasian male identified by a left toe and right wrist tag with name and history number. The body is 175 cm in length and weighs 98.4 kg. Medical photographs are taken for identification purposes. The skin is unremarkable. The right and left pupils measure 5 mm and 5 mm, respectively. The sclerae and conjunctivae are unremarkable. The ears are unremarkable. The nares are remarkable for bloody secretions. The oropharynx is edentulous without dentures in place and is remarkable for bloody secretions. The neck is remarkable for a double lumen intrajugular venous catheter and bruising. The thorax is symmetrical and remarkable for a dialysis catheter along the right subclavicular area, a palpable pacemaker along the left subclavicular area and a 22 cm well-healed scar along the midsternal area. The abdomen is distended and is remarkable for a 30 cm scar. The back is unremarkable. The external genitalia are those of adult male. The penis is uncircumcised. The upper and lower extremities are symmetrical, without absence of digits, and exhibit no edema. There is a 4.2 x 1.1 cm wound on the right anterior forearm, and gauze covering a 1.1 x 1.1 cm partially healed wound on the left posterior forearm. The posterior aspect of the wrist is ecchymotic with an arterial line in place. The anterior portion of the calves are remarkable for a brownish discoloration and a decrease in hair density bilaterally.

SEROUS CAVITIES: The pericardial cavity contains no significant fluid. The left and right pleural cavities contain 220 mL and 1000 mL of serous fluid, respectively. The pleura of both lungs and the pericardium are adhered to the chest wall. All organs are in the normal anatomic position.

CARDIOVASCULAR SYSTEM: The heart weighs 750 gm. The epicardial and pericardial surfaces are adhered. The coronary arteries arise normally and show a balanced pattern with the maximum atherosclerotic occlusion approaching 40%. Bread-loaf sections through the apex of the heart reveal unremarkable red-brown myocardium. The left ventricular wall measures 2.1 cm and the right ventricular wall measures 0.9 cm at 1 cm below the respective atrioventricular valve annuli. The left and right atria and right ventricle appear to be dilated. Sectioning the base of the heart by blood flow reveal mildly calcified tricuspid, pulmonic, and mitral valves measuring 11.5 cm, 7.1 cm, and 11.7 cm, respectively. The aortic valve is status post prosthetic valve replacement and appears to be without excrescences or nodules. The foramen ovale is closed. The aorta shows severe atherosclerosis, Grade VII/VII. The ostia of the major aortic vascular branches are patent. The pulmonary arteries have no atherosclerosis.

RESPIRATORY SYSTEM: The lungs and trachea weigh 1650 gm and show normal lobation. The pleural surface is fibrous and is adhered to the chest wall. Cut sections reveal red-brown parenchyma which is remarkable for diffuse emphysema. Pulmonary arteries are free of thromboemboli. The bronchial tree is unremarkable.

The autopsy is restricted to chest analysis.

kms/10/6/2008 Kristen M. Stashek, MD
Simone M. Dustin, M.D.
Vickie Y. Jo, M.D.

DEPARTMENT OF LABOR
ESA-OWCP-DCMWO
JOHNSTOWN PA 15001
JOHNSTOWN PA 15001

MAR 04 2009

FEB 12 2009

Microscopic Description

I. Key to Slides:

Slide 1: Left ventricle with pericardium
Slide 2: Right ventricle, right atrium
Slide 3: Left anterior descending
Slide 4: Lung, right upper lobe
Slide 5: Lung, right middle lobe
Slide 6: Lung, right lower lobe
Slide 7: Lung, left upper lobe
Slide 8: Lung, left lower lobe

II. Microscopic descriptions

LUNGS (5 H&E): Sections of the lungs demonstrate diffuse emphysematous changes. There are multifocal areas of anthracotic nodules. Mild pulmonary hypertensive vascular changes are present. Bacteria and foreign material are seen in the bronchial tree, without an inflammatory infiltrate. There is pleural anthracosis and pleural thickening in the left lower lobe. There is no evidence of pulmonary emboli.

HEART (3 H&E): Microscopic examination of the heart reveals evidence of ischemic cardiomyopathy. The left ventricle shows multiple microscopic areas of subacute infarction with macrophages present. Both the left and right ventricle show multiple microscopic areas of remote infarction. Sectioning of the LAD artery shows a moderate atherosclerosis (40%) with calcification.

Case Discussion

The gross and histologic findings in this case are consistent with simple coal worker's pneumoconiosis (SCWP). The pathologic features of SCWP include the presence of dust macules and focal emphysema, both of which are required for diagnosis. In this case, the decedent had both diffuse pulmonary emphysema and multifocal areas of dust macules. The histologic findings were not severe enough to diagnose complicated coal worker's pneumoconiosis, which requires gross and microscopic zones of fibrosis that most commonly affect the posterior portions of the upper lobes.

Other findings in this case include areas of subacute and chronic myocardial infarction. The decedent's coronary arteries had moderate atherosclerosis, but given his history of repeated GI bleeds, he was prone to bouts of hypotension, which could be responsible for his myocardial ischemia. The decedent also had biatrial and right ventricular dilatation, but this is explained by the histologic findings of diffuse emphysema and pulmonary hypertension.

REFERENCES:

Travis et al. Non-neoplastic disorders of the lower respiratory tract. 2002. 1st series. Fascicle 2. pg 797

DEPARTMENT OF LABOR
ESA-OWCP-DCMWG
JOHNSTOWN PA 15901

MAR 04 2009

DEPARTMENT OF LABOR
ESA-OWCP-DCMWG
JOHNSTOWN PA 15901
FEB 19 2009

Everett F. Oesterling, Jr., M.D.

Medical Legal Consultant
in the Pathology of Occupational Lung Diseases

July 28, 2009

Judy A. Hammonds, CLA
Jackson Kelly PLLC
Attorneys at Law
500 Lee Street East - Suite 1600
P.O. Box 553
Charleston, West Virginia 25322

RE: Jackie Lee Fitzwater, deceased
Patricia Ann Fitzwater, surviving spouse, vs.
Westmoreland Coal Company
JK Ref. No. 2809/340

Dear Ms. Hammonds:

This letter is written in response to your letter of July 8, 2009 concerning the above named decedent miner and his claimant widow. Since receiving your letter I have reviewed the materials which you forwarded to me. They consisted of histologic sections which had been prepared at the University of Virginia Health System's Department of Pathology which bore the number A08-149 with the name Fitzwater, J and the sequential numbers 1 through 8. The slides were of good technical quality, the lung sections included multiple cross sections on three of the five submitted slides. Thus there appear to be adequate sections to answer questions concerning this gentleman's lung disease, as well as his heart disease. The remaining three sections were from the coronary vessel and one from the right and from the left ventricle.

To illustrate and document my findings I have utilized a series of photographic representations. First please note a photocopy that has been significantly magnified as you can tell from the centimeter ruler in the left margin of this photocopy. It demonstrates the three slides from the right lung. You will note they are numbered 4, 5 and 6. Hopefully even utilizing this modality it becomes quite clear that there is no gross evidence of black pigment noted, and indeed the lung tissue appears fairly normal.

Next I have inserted a high resolution computer generated image of the slide designated 4, this having been submitted from the right upper lobe. This is important since the upper lobe typically is an area in which we see significant amounts of coal dust if it has.

621 South Negley Avenue ♦ Pittsburgh, PA 15232-1815

Phone 412-661-0553 ♦ Fax 412-661-3132

www.eoesterling@mac.com

Ms. Hammonds

Page 2

July 28, 2009

been inhaled in sufficient quantities and here we see very little evidence of black pigment. If you look carefully along the right margin of this tissue cross section you will see a pink membrane which appears minimally thickened near its upper pole and at that point there is very modest black pigment noted. However throughout the interstitium, the remaining portion of this cross section, we do not see black pigment. Moreover the air sacs remain relatively normal in size with only minimal enlargement noted.

Turning the microscope photo 1 was obtained from this slide at 30x. You will note in the right margin linear 1 mm. markings on a clear ruler indicating a tissue cross section approximating 4 x 6 mm. contained within this photographic field. Thus the area that shows minimal pigmentation measures less than 1 mm. in its dimension. At 60x we can examine this in photo 2 and we do see very modest quantities of black pigment within the immediate subpleural tissue. At 150x in photo 3 again we see this very minimal black pigment and the pleural surface is noted along the right aspect as a smooth membrane. Beneath the subpleura the interstitium shows no pigment. At 600x photo 4 shows this area of black pigmentation and please note the prominent vascularity which is present. Typically the pleura is rich in vascularity including both venous capillaries and lymphatic capillaries. Thus if dust has been inhaled in any significant quantity it will be concentrated in this area. Obviously that was not the case. With partial polarized light in photo 5 we do see occasional bright white silicate crystals and rare smaller less birefringent silica crystals. Thus this is of coal dust origin and we are looking at anthracotic pigmentation of the pleural surface, but no true macular disease.

Turning to the interstitium on this slide photo 6 was obtained at 60x from the interstitial component of this same slide and here we see minimal enlargement of several of the air spaces, but also we are beginning to notice some cellular material within the air sacs. At 150x photo 7 shows more clearly the alveolar pattern of this lung and the obvious evidence of cells within the air sacs. Photo 8 at 600x shows the cells within these normal alveolar sacs and here we see several distinct cell types. First there are multiple cells that have a very finely stippled cytoplasm, the pigmentation appearing to have a pale tan color. By contrast there is a cell that is also mononucleated that shows very coarse mahogany brown granules. This cellular change will be addressed at a later point. Also I believe if you look carefully there are rare red blood cells present. As for the capillaries within the alveolar membranes at this point, they appear normal. The cells with the finely stippled cytoplasm are of interest since these are typically associated with the inhalation of tobacco smoke. Thus one must consider that this gentleman was inhaling at least modest quantities of tobacco smoke, either primarily or secondarily.

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If you refer to the prosector's protocol you will note that in the microscopic description there is a reference to nodules present within the lung. I did not see any nodules of coalworkers' pneumoconiosis in any of the lung sections, however the photocopy of slides 7 and 8 which is included next, does show slide 7 and I believe if you look in the right lower aspect of that tissue section there is a pigmented ovoid nodular appearing structure. Also before leaving this please look at slide 8 and notice the thickening of the pleura which can be seen along the left margin of this tissue cross section.

With a high resolution computer generated image of slide 7, in this instance the left upper lobe, we now see the nodular area in the lower aspect of the left surface. Please note even utilizing this image the very sharp delineation between this structure and the adjacent lung tissue due to a well formed pink membrane, a capsule. Also note the purple ovoid areas within this structure, these representing lymphoid follicles, the normal component of lymph nodes.

To document this I have utilized the microscope and photo 9 obtained at 30x shows the millimeter markings across the upper margin indicating that this nodular structure measures approximately 6 x 4 mm. We see some black pigment and areas of pink fibrous tissue, but also clearly we see ovoid purple areas and a well formed capsule. At 60x in photo 10 we see the capsule along the left margin of this structure and beneath that an obvious dilated sinusoid. Also note the aggregates of purple cells and the relatively sparse quantities of black pigment. Concentrating on the black pigment in photo 11 at 150x we do see the pigment suspended within the reticuloendothelial component of this lymph node and do see a lymphoid follicle in the left lower aspect and an obvious capsule with a subcapsular sinusoid along the left portion of the node. At 600x photo 12 shows the subcapsular sinusoids in the left margin and then shows the areas of black pigmentation within the interstitium of the lymph node. Applying partial polarized light to this field in photo 13 we see bright elongate silicate crystals and smaller less birefringent silica crystals. Thus again we are looking at coal dust which has been concentrated within this intrapulmonary lymph node. Obviously this is very modest deposition of pigment and the node shows very minimal enlargement. This is not a significant degree of pigmentation since the lymph nodes filter the lymphatic fluids to remove any dust that has been inhaled and is being removed through the lymphatic fluids. The relatively modest quantities of dust here again suggest a very low level of dust inhalation. Photo 14 also with partial polarized light shows one of the lymphoid follicles and clearly we do not see the crystalline material here, these are normal lymphocytes and thus again we are looking at an intrapulmonary lymph node with modest anthracotic pigmentation and not a nodule of coalworkers' pneumoconiosis.

Ms. Hammonds

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Photo 15 was obtained at 60x from this same slide to show another interesting finding for in the right aspect you will note there are some areas where the interstitium appears slightly thickened. At 150x this becomes more evident in photo 16 and we can clearly see clusters of cells within the air sacs. At 600x photo 17 shows this area and one of the air sacs and clearly within its lumen we do see nucleated mononuclear cells, as well as acute inflammatory cells and please note the stippling of black dots which can be seen, these representing bacteria, thus we are looking at an infectious process. Also note the alveolar membranes here are thickened and show numerous round purple cells, chronic inflammatory cells. Here we are looking at an area of bacterial growth and chronic interstitial lymphoid pneumonitis. With partial polarized light in photo 18 you will note the absence of crystalline material indicating that these black structures are indeed microbes and not coal dust.

Photo 19 is from the slide designated 8 at 60x from the left lower lobe. Now we are seeing a different problem within the lungs for here we see an almost solid appearing lung between dilated vascular structures. At 150x in photo 20 we see this cellular material within the air sacs and widening of the interstitium. Photo 21 at 600x shows an area where we have marked early interstitial fibrous tissue with diffuse chronic inflammation and photo 22 at 600x again shows some of the dot-like microbes, as well as inflammatory cells and interstitial fibrosis. Thus in the lower lobe we are looking at collapse, i.e. atelectasis, as well as a diffuse chronic and acute pneumonitis.

Slide 6 was obtained from the right lower lobe and here we see a computer generated image to demonstrate this slide. Here we do not see as much cellular infiltrate, but the lung still does appear more solid and has a reddened appearance.

With the microscope in photo 23 at 60x we begin to see obvious cells within the air sacs and minimal thickening of the interstitium of the lung. At 150x in photo 24 we can see a small vessel in the lower aspect and cuffing that vessel we do see very modest quantities of black pigment while within the adjacent lung we see numerous nucleated cells within the air sacs containing a mahogany brown pigment which at 600x in photo 25 appears markedly granular. This is the same material that we saw previously and this represents hemosiderin, a breakdown byproduct of red blood cells and the hemoglobin which has been released into the air spaces. This indicates chronic passive congestion and please note the interstitium of the lung shows fibrosis and marked chronic inflammation. Also note in the lower pole the black pigment which with polarized light in photo 26 does show crystalline material, thus this is very minimal anthracotic cuffing of the vascular structures, while the cells in the air sac do not show this crystalline material, thus they are totally unrelated to coal dust inhalation.

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Hopefully it has become quite evident from the previous photos that this gentleman experienced a very mild anthracotic pigmentation within the pleural surface with perivascular and peribronchiolar cuffing with anthracotic pigment. None of these achieve a size that warrants a diagnosis of macular coalworkers' pneumoconiosis and clearly there is no evidence of nodular change except for the interstitial lymph node which does not constitute coalworkers' pneumoconiosis. Therefore I would state the following with reasonable medical certainty:

1. There is evidence of minimal anthracotic pigmentation within this gentleman's pleura with a perivascular and peribronchiolar cuffing.
2. This level of dust deposition would not alter pulmonary function.
3. Without alterations in pulmonary function the dust should not have produced respiratory symptomatology.
4. Without alterations in structure the dust would not have hastened, contributed to or caused his demise.

As for his lifetime symptomatology the high resolution computer generated image of slide 5 was obtained from the right middle lobe and again shows a pleural membrane along the upper and right margin while within the interstitium of the lung we do note a slight enlargement of some of the air sacs. This however is not marked.

Turning to the microscope photo 27 obtained at 30x shows this lung interstitium and again we do see slight enlargement of the air sacs, however many small normal sacs persist. At 60x photo 28 again shows several of the areas with minimal enlargement and please note that these areas are partially traversed by blunted membranes, ruptured alveolar membranes. Photo 29 at 150x shows one of the enlarged air spaces and clearly we do see the blunted ruptured pleural membranes, but please note the surrounding normal air sacs. At 600x in photo 30 we are looking at the normal air sacs and we do see one other abnormality for here we do see numerous ovoid small purple cells within the alveolar membrane, these are chronic inflammatory cells, again indicating a component of interstitial inflammation involving this gentleman's lung tissue. This is not related to coal dust.

As for the other changes photo 31 was obtained at 150x from one of the small muscular pulmonary arteries and here I believe you can see the irregular lumen with several small recanalized channels and a markedly thickened muscle coat. At 600x photo 32 shows this muscle coat with a normal circular muscle traversing along the right aspect while the

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intimal surface shows medial muscular hypertrophy. This would indicate that this gentleman was experiencing some component of pulmonary hypertension and indeed this could be due to his minor emphysematous change although it is not related to coal dust. It would also be the case if this gentleman was experiencing progressive heart failure which indeed the slides also suggested.

Looking at the cross sections of the left ventricle there is evidence of this gentleman's cardiac disease which had produced most of the changes that we have discussed within his lung tissue. Here at 60x in photo 33 we see a central pale area surrounded by fibers which have a fairly bright red appearance. At 150x photo 34 shows the pale area to again have some small cellular infiltration while the surrounding muscle fibers do have a brighter red color. At 600x photo 35 shows this area and within this we see early fibrous tissue, chronic inflammatory cells and macrophages containing hemosiderin indicating previous bleeding into this area. This is an area of resolving myocardial infarction somewhere in excess of 4 to 6 weeks in duration. The adjacent muscle fibers appear markedly reddened, they are shrunken showing halos surrounding them and loss of their nuclei. Thus they do demonstrate ischemic death of these fibers. Clearly there is ongoing ischemic myocardiopathy with both acute and more remote areas of myocardial infarction which are microscopic. It is this entity that has produced a major part of this gentleman's pulmonary problems.

Photo 36 shows the periphery of the heart at 60x and now we see several interesting findings for here you will note a very pale pink area within the myocardium in the right while adjacent to that we see the very dense pink tissue of the pericardium on the left. At 150x photo 37 shows the area in the right aspect, this representing an area of myocardial scarring, i.e. remote myocardial infarction, while the pericardial surfaces are shown in the left aspect. Again the very bright pink collagen. At 600x in photo 38 we can better appreciate the fibrosis of the pericardium, thus this gentleman did demonstrate diffuse pericardial fibrosis. This would limit the excursion of the heart wall and would again impede the heart function. Thus his heart demonstrated multiple significant changes which would have impeded its function and would have impacted on his lung function.

In concluding I would restate with reasonable medical certainty that coal dust was in no way a factor in this gentleman's demise, his lung disease was primarily related to his cardiac disease which is unrelated to coal dust exposure. Unfortunately without other organs one cannot totally assess the absolute cause of death and I believe if you look at the death certificate you will note that they listed renal failure, congestive heart failure and infective endocarditis. There is no mention of coalworkers' pneumoconiosis. I would be

Ms. Hammonds

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July 28, 2009

largely in agreement with the findings in the autopsy, but do find have some differing opinions from those set forth in the autopsy protocol.

Hopefully this answers any questions which you might raise, if not, please do not hesitate to contact me at your earliest convenience for additional detail.

Respectfully submitted,

Everett F. Oesterling, Jr., MD, FCAP, FASCP

4 JP
FITZWATER, J
RECUT

UVA Health Systems

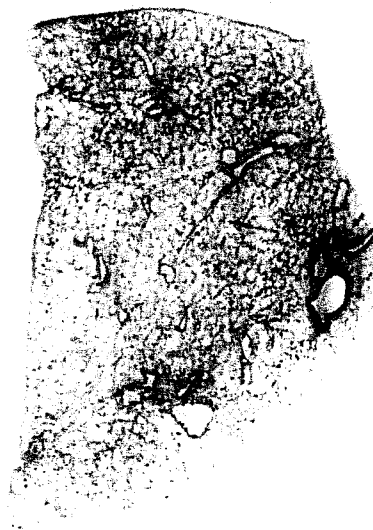
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5 JP
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UVA Health Systems

Leica IP 3



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FITZWATER, J
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UVA Health Systems

Leica IP 3



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SLIDE 4

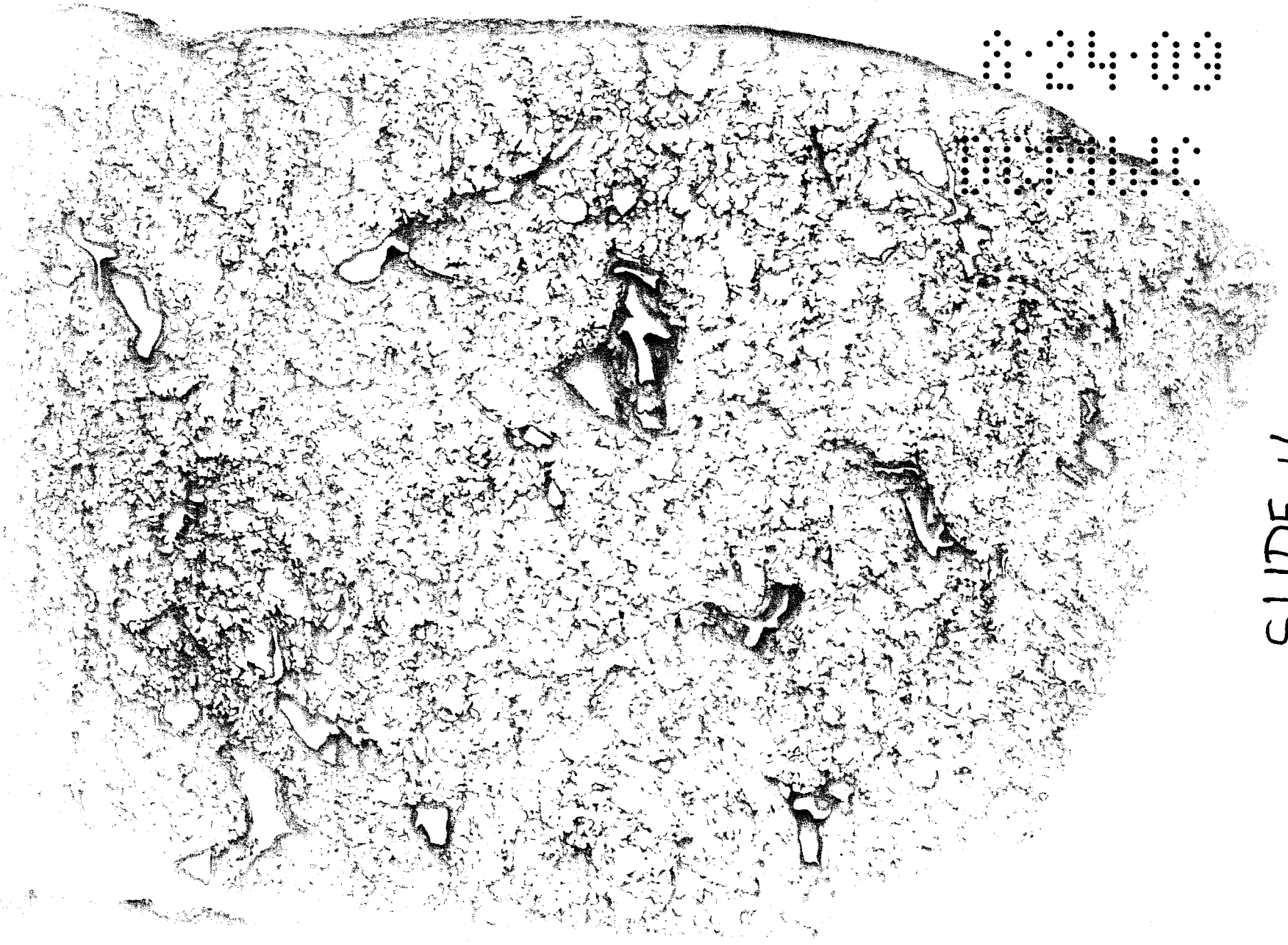
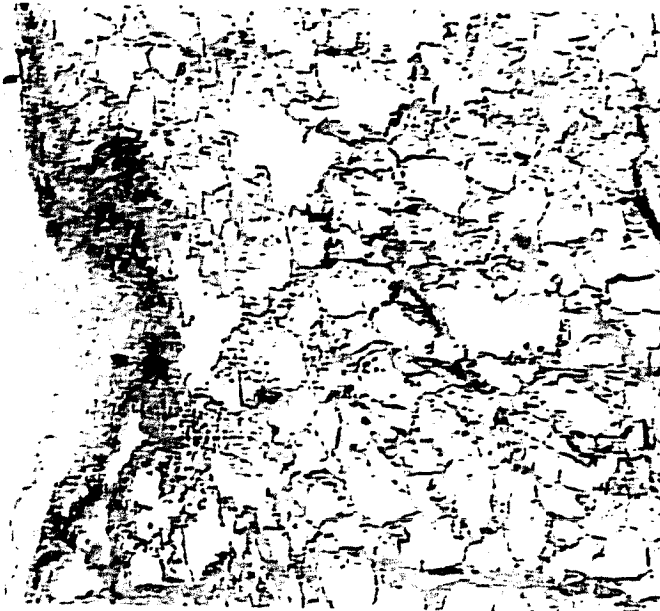


PHOTO 2



A08-149

PHOTO 1



JACKIE LEE FITZWATER

PHOTO 3



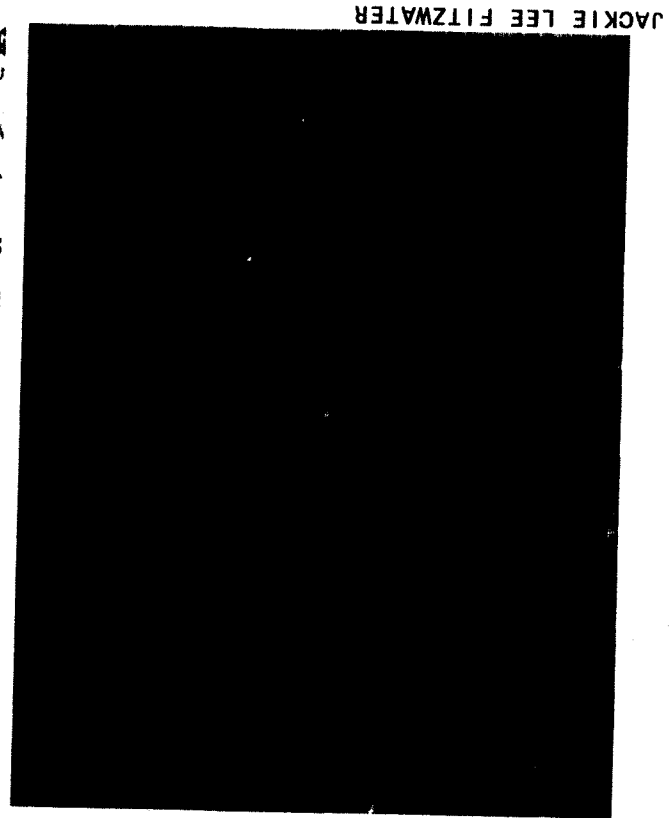
JACKIE LEE FITZWATER



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PHOTO 4

PHOTO 5

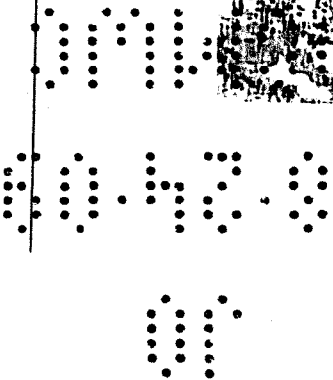


JACKIE LEE FITZWATER

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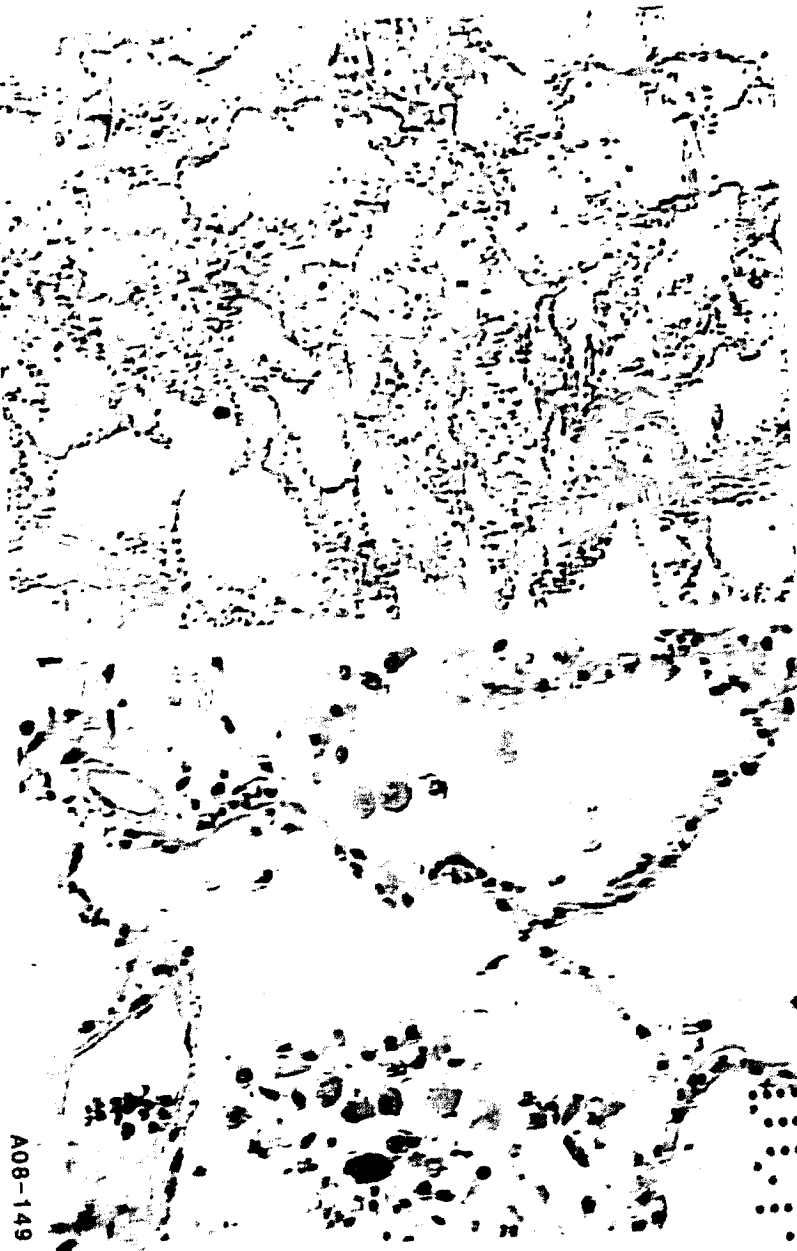
PHOTO 6



13

PHOTO 7

JACKIE LEE FITZWATER



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PHOTO 8

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UVA Health Systems

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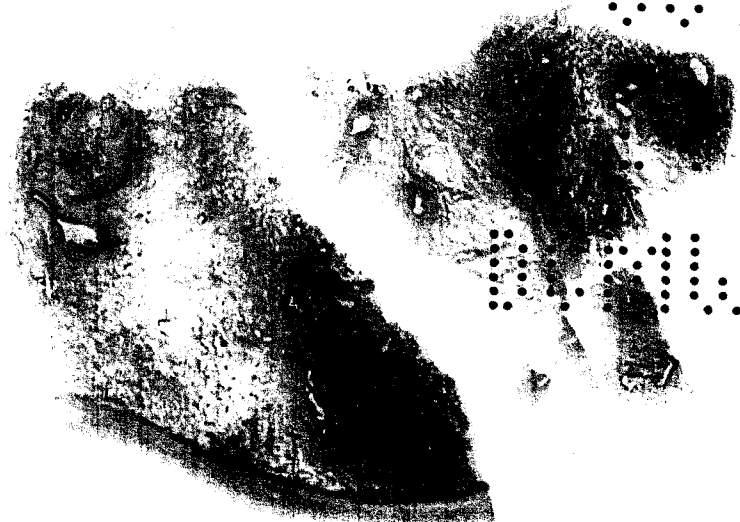
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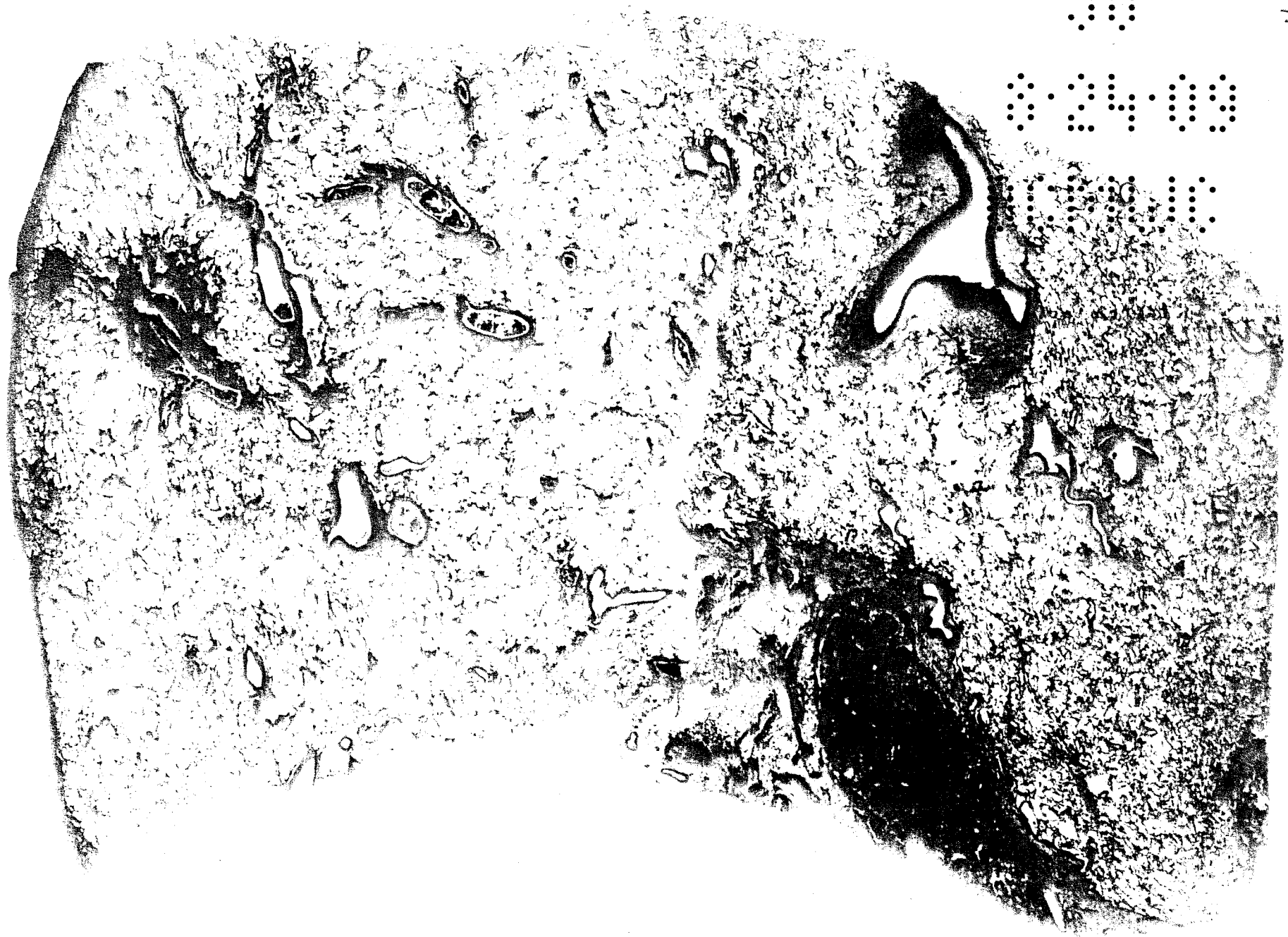
FITZWATER, J

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UVA Health Systems



15



SLIDE 7

16

PHOTO 9



JACKIE LEE FITZWATER



A08-149

PHOTO 10

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02400
02400

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PHOTO 11



JACKIE LEE FITZWATER



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PHOTO 12

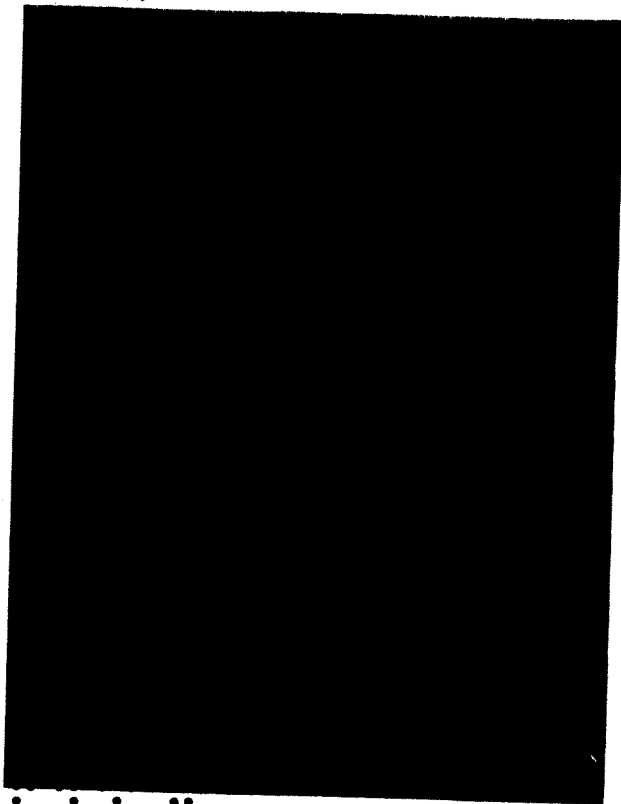
PHOTO 13



JACKIE LEE FITZWATER

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PHOTO 14



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PHOTO 15

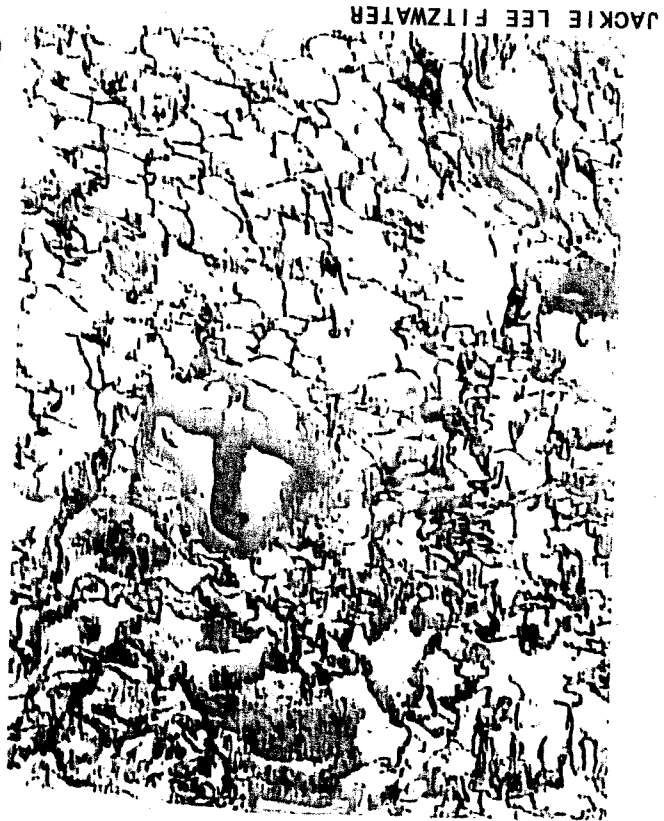


PHOTO 16



011400

A 5x5 grid of dots forming the number 2020. The first column has 5 dots, the second has 4, the third has 3, the fourth has 4, and the fifth has 5. The dots are arranged to form the digits 2, 0, 2, and 0.

A 3x3 grid of dots. The first two columns each contain 3 dots, forming the number 10.

PHOTO 17



JACKIE LEE FITZWATER



A08-149

PHOTO 18

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00-24-00
00-00-00

PHOTO 19



JACKIE LEE FITZWATER

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PHOTO 20



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PHOTO 21



JACKIE LEE FITZWATER



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PHOTO 22

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SLIDE 6

PHOTO 23



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PHOTO 24



PHOTO 25



JACKIE LEE FITZWATER



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PHOTO 26

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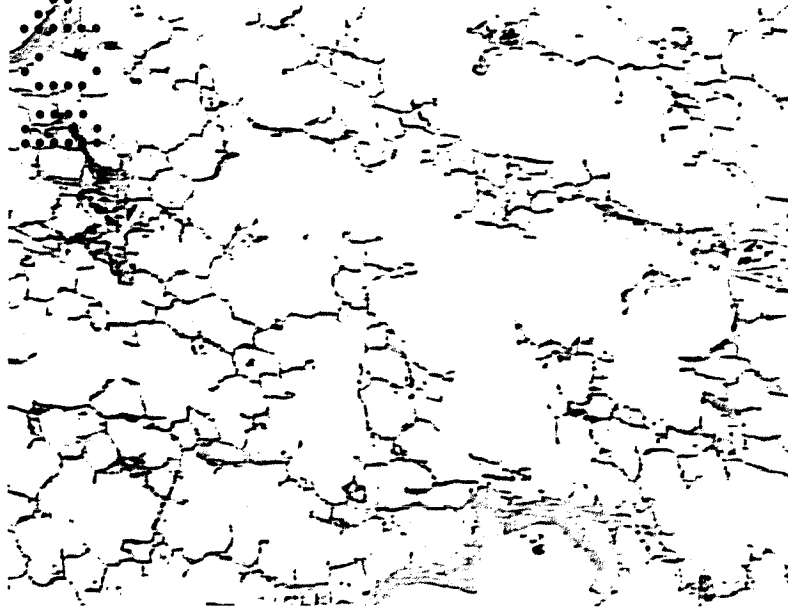
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SLIDE 5

PHOTO 28

A08-149



JACKIE LEE FITZWATER

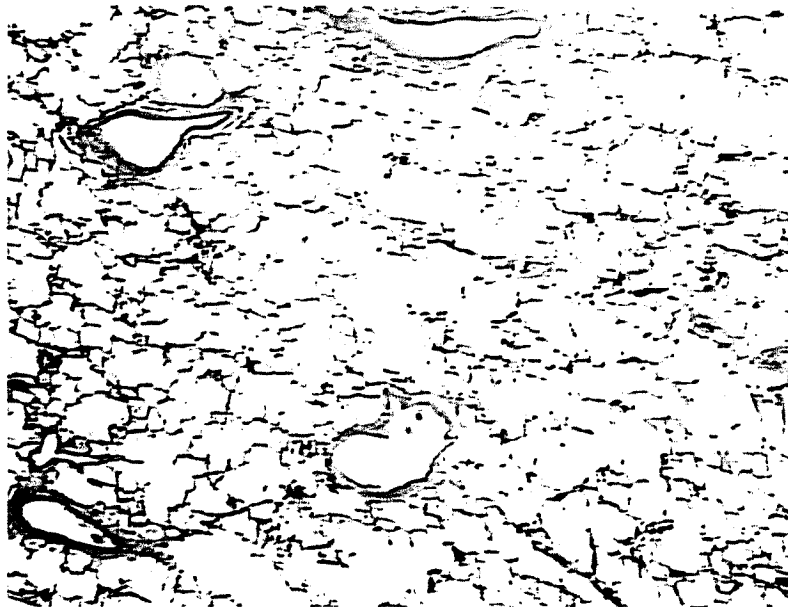


PHOTO 27

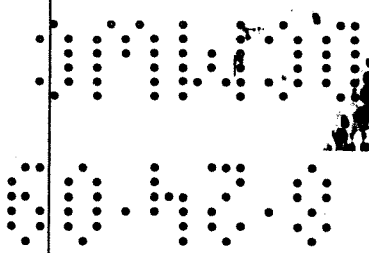
PHOTO 29



JACKIE LEE FITZWATER

A08-149

PHOTO 30



42

PHOTO 31



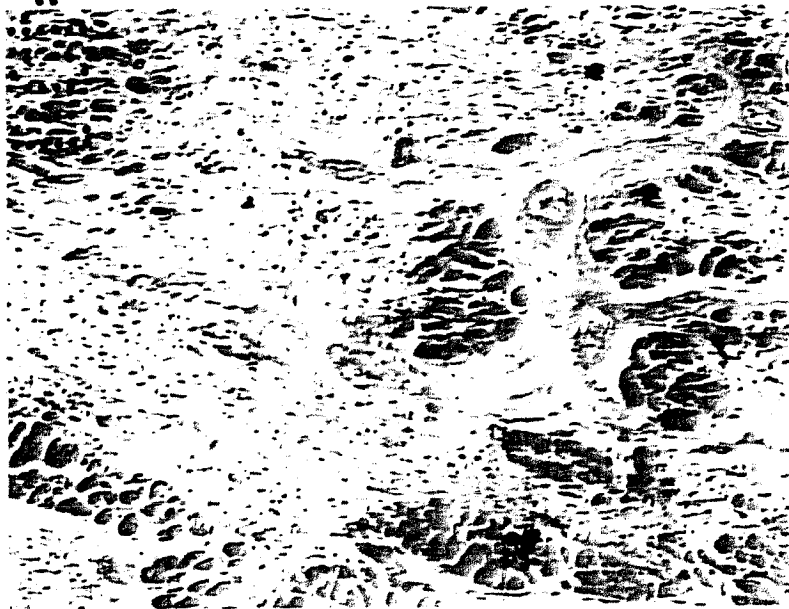
JACKIE LEE FITZWATER



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PHOTO 32

PHOTO 34



A08-149

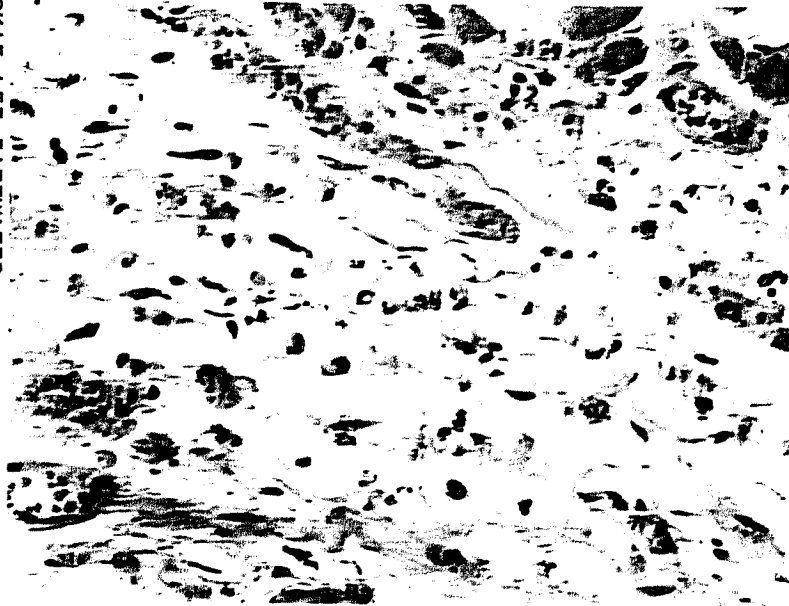


JACKIE LEE FITZWATER

PHOTO 33

PHOTO 35

JACKIE LEE FITZWATER



A08-149

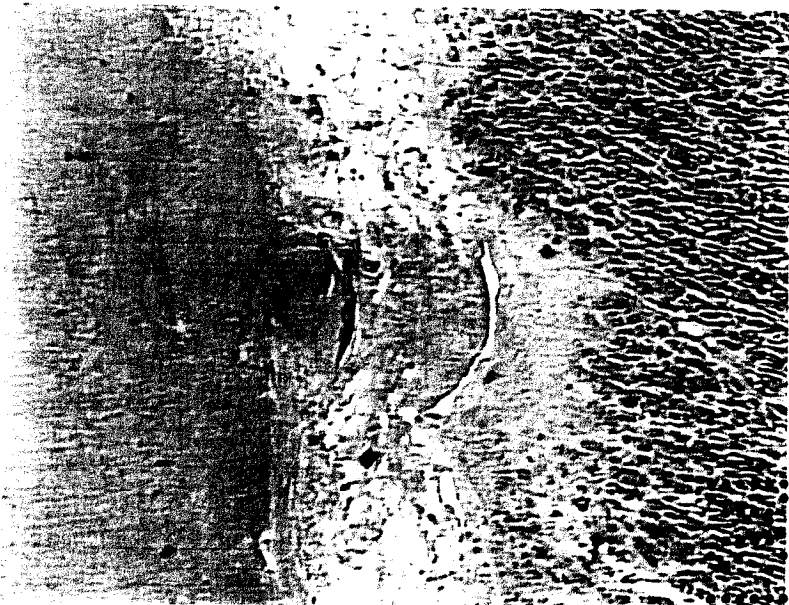


PHOTO 36

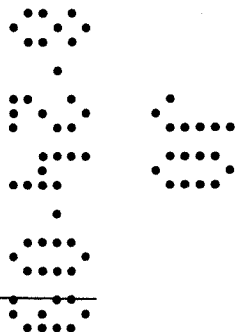


PHOTO 38



A08-149

PHOTO 37



JACKIE LEE FITZWATER

Curriculum Vitae

Everett F. Oesterling, Jr. MD, FCAP, FASCP

Consultant in the Pathology of Occupational lung diseases

BORN: August 7, 1935
Butler, Pennsylvania

EDUCATION: Juniata College, Huntingdon, PA 1953-1957 BS
Thomas Jefferson Medical College, Philadelphia, PA 1957-1961 MD
Methodist-Episcopal Hospital, Philadelphia, Pa
Rotating Internship 1961-1962
Thomas Jefferson Medical College Hospital
Resident in Pathology 1962-1966
Clinical Preceptorship in Nuclear Medicine 1966
Hahnemann Medical College, Philadelphia, PA
Basic Isotope Methodology 1966

MEDICAL LICENSE:
Pennsylvania Physician & Surgeon 1962 till present

BOARD CERTIFICATIONS:

American Board of Anatomical Pathology 1966
American Board of Clinical Pathology 1968
American Board of Nuclear Medicine 1972

EDICAL STAFF APPOINTMENTS:

Altoona General Hospital, Altoona, PA
Associate Pathologist and Director of Nuclear Medicine 1966-1968
Consultant in Nuclear Medicine 1970-1974

The Indiana Hospital, Indiana, PA
 Director of Pathology and Nuclear Medicine 1968-1974
 Consultant in Nuclear Medicine 1982-1984

The Torrence State Hospital, Torrence, PA
 Clinical Director of Laboratory 1968-1974

The Armstrong County Memorial Hospital, Kittanning, PA
 Consultant in Pathology 1968-1974

Ohio Valley General Hospital, McKees Rocks, PA
 Director of Nuclear Medicine 1974-2008
 Associate Pathologist 1974-1980
 Chairman Department of Pathology 1980-2008
 Medical Staff Secretary-Treasurer 1985-1987
 Medical Staff President Elect 1987-1989
 Medical Staff President 1989-1991
 Medical Staff Executive Committee 1980-2008
 Emeritus Staff 2008

St. John's General Hospital, Pittsburgh, PA
 Director of Nuclear Medicine 1974-1994
 Associate Pathologist 1974-1983
 Chairman Department of Pathology 1983-1994

North Hills Passavant Hospital, Pittsburgh, PA
 Consultant in Pathology 1974-2003

The Clinical Pathology Facility, Inc. Pittsburgh, PA
 Consultant in Pathology 1976-1994

The Elwood City Hospital, Elwood City, PA
 Consultant in Pathology 1995-1997

TEACHING APPOINTMENTS:

Indiana University of Pennsylvania, Indiana, PA
 Professor of Biology and Radiation Safety

Community College of Allegheny County, Pittsburgh, PA
 Adjunct Clinical Professor of Nuclear Medicine Technology 1980-2008

Technicare International,
 Preceptor in Visiting Professors Program (Peoples Republic of China) 1985

PROFESSIONAL MEMBERSHIPS:

College of American Pathologist (Fellow) 1998 till present

American Society of Clinical Pathologists (Fellow) 2003 till present

Pittsburgh Pathology Society 1974 till present

Pulmonary Pathology Society 2005 till present

American Medical Association 1966-2002 (Lifetime member since)

Pennsylvania Medical Society 1966 till present

Allegheny County Medical Society 1974 till present

Indiana County Medical Society 1968-1974

Blair County Medical Society 1966-1968

Pennsylvania Society of Clinical Pathologists 1966-1986

American Society of Nuclear Medicine 1966-2001

President of Pittsburgh Chapter 1978-1980

Member National Board of Trustees 1978-1980

Chairman of Arrangements for Chapter Annual Meetings 1978-1982

Pennsylvania College of Nuclear Physicians 1974-1994

Board of Directors 1974-1981

Vice President 1981-1982

Treasurer 1982-1984

Secretary 1984-1988

Delegate to Pennsylvania Medical Society Interspecialty Committee 1988-1994

American Society of Nuclear Cardiology (Founding Member) 1993-2000

36

MEDICAL LEGAL:

Coroner's Pathologist Blair County, PA 1968-88

Coroner's Pathologist Indiana County, PA. 1968-70

Indiana County, PA. Coroner 1970-74

Medical Legal Committee ACMS 1986-94

CONTINUING MEDICAL EDUCATION:

Vllth International Pneumoconioses Conference

International Update on Occupational and Environmental

Respiratory Diseases - Baylor College o Medicine

American College of Chest Physicians - Lung Pathology

ASCP Update in Pulmonary Pathology

Harvard Medical - Current Concepts in Asbestos-Related

Lung Disease

Society of Pulmonary Pathologists Biennial Meeting and

Seminar

37



P.O. Box 660988 Birmingham, AL 35266-0988

Phone: 888.823.4496 Fax: 866.759.9843

Website www.AMCSClaims.com

March 27, 2009

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

UNITED STATES DEPARTMENT OF LABOR
ESA/OWCP/DCMWC
319 Washington Street
Johnstown, PA 15901
Attention: Elizabeth Gojmerac, Claims Examiner

Re: Claim Number: XXX-XX-5934 LW C
Insured: Wv CWP Fund
Claimant: Patricia A. Fitzwater
Miner: Jackie L. Fitzwater
Miner's SSN: XXX-XX-5934
Federal Black Lung Widow's Claim

Dear Ms. Gojmerac:

This letter confirms receipt a Notice of Claim dated March 5, 2009 indicating that Lady H Coal Co. Inc. is being considered as responsible operator in the above captioned Federal Black Lung Widow's Claim.

While we agree that we should be a party in interest to all future proceedings in this matter, employment data in the file may not be final. Therefore, we reserve the right to contest our liability as responsible operator in this instance, if and when additional information becomes available.

Please forward to us copies of all future correspondence in this matter. We are enclosing an Operator Response to this Notice of Claim.

Thank you for your attention to this matter.

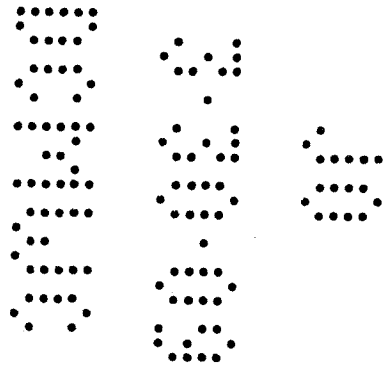
Very Truly Yours,
AMERICAN MINING CLAIMS SERVICE, INC.

A handwritten signature in cursive script, appearing to read "Lisa Evans".

Lisa Evans
Claims Adjuster

Enclosure

Cc: Mrs. Patricia A. Fitzwater
Lady H Coal Co. Inc.
Westmoreland Coal Co. c/o Wells Fargo Disability Mgt.
Douglas Smoot, Esquire - Jackson Kelly, PLLC



**WELLS
FARGO**

P.O. Box 3389
Charleston, WV 25333-3389
304.556.1100 Voice

Wells Fargo Disability Management

July 24, 2009

Elizabeth Gojmerac
Claims Examiner
U. S. Department of Labor
ESA/OWCP/DCMWC
1 Tech Park Dr Ste 250
Johnstown PA 15901-1267

Re: Jackie Fitzwater (Deceased)
Patricia Fitzwater (Claimant)
Federal Black Lung Claim No.: 09-0006
Control No.: 14710143
Social Security No.: xxx-xx-5934

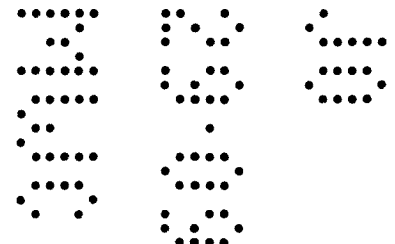
Dear Elizabeth Gojmerac:

This is in response to your Schedule for the Submission of Additional Evidence dated July 15, 2009. Westmoreland Coal Company respectfully requests the responsible operator issue be re-examined and an amended Schedule for the Submission of Additional Evidence be issued.

In the rationale for naming Westmoreland Coal Company as the responsible operator, it is stated that Westmoreland Coal Company received the Notice of Claim on February 2, 2009, and then failed to timely respond to the Notice of Claim or to timely request an extension of time for response. Enclosed is a copy of the Controversion dated February 17, 2009. In this Controversion, we requested an extension of time, as the Social Security Earnings Report was not provided with the Notice of Claim.

We also requested dismissal, as this mine site was sold to Lady H Coal Company on March 28, 1986, insured through the WV CWP Fund policy number 73000031. The claimant continued working for Lady H Coal Company from April 1986 through July of 1994. In further examination of this claim's responsible operator issue, we have enclosed additional information regarding the mine site for your review.

According to our records, on February 17, 2009, we had a telephone conversation with you regarding this claim. During this conversation, we questioned the Notice of Claim, as our records reflect this claim was an Awarded Transfer case. You indicated you would review this issue. On March 5, 2009, you issued another Notice of Claim naming Lady H Coal Company insured by the West Virginia Coal Workers' Pneumoconiosis Fund.





WELLS
FARGO

Elizabeth Gojmerac
Re: Jackie Fitzwater (Deceased)
Page 2
July 24, 2009

We look forward to hearing from you regarding the responsible operator issue and our request for a revised Schedule for the Submission of Additional Evidence. Westmoreland Coal Company reserves the right to further contest its designation as a potential liable operator, if further evidence becomes available. If you have questions, please call me at 304.556.1151.

Sincerely,



Jeffrey A. Beckner
Claims Consultant
Occupational Disease Programs
304.556.1112 Fax
jeffrey_beckner@wellsfargois.com

JAB/map

Enclosures

cc: Lisa Fitzwater – American Mining Claims Service, PO Box 660988, Birmingham AL 35266-0988
Patricia A. Fitzwater – PO Box 312, Quinwood WV 25981
Douglas Smoot – Jackson Kelly PLLC, Charleston WV

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www.jacksonkelly.com

dsmoot@jacksonkelly.com

(304) 340-1368

July 24, 2009

Ms. Elizabeth Gojmerac
Claims Examiner
Department of Labor
Greater Johnstown Tech Park
1 Tech Drive, Suite 250
Johnstown, PA 15901-1267

Re: Federal Black Lung Claim
Patricia A. Fitzwater, widow of Jackie Fitzwater
OWCP No. xxx-xx-5934
Westmoreland Coal Company (operator)
J K Ref No. 2809/340

RESPONSE TO SCHEDULING ORDER

Dear Ms. Gojmerac:

We represent Westmoreland Coal Company in the above referenced federal black lung claim. We have received the "Schedule for the Submission of Additional Evidence" issued by your office. My client **DISAGREES** with the initial determination that the evidence establishes entitlement to benefits. Specifically, we **DISAGREE** with your findings of years of coal mine work, pneumoconiosis, cause of pneumoconiosis, and cause of death.

We also **DISAGREE** that my client is the correct responsible operator. My client reserves the right to contest the responsible operator issue and to submit additional documentary or testimonial evidence that demonstrates that Mr. Fitzwater last worked for a company other than Westmoreland Coal Company for a cumulative period of at least ~~one~~ full year. Westmoreland Coal Company identifies Patricia Fitzwater as a potential 20 C.F.R. § 725.414 (c) witness pertaining to the liability of the potentially liable operator.

We object to the Scheduling Order on the following grounds. The Scheduling Order and the amended regulations it is based upon are consistent with the statutory requirement contained in the Black Lung Benefits Act (BLBA) mandating that "all relevant evidence shall be considered" by an adjudicator in a black lung claim. 30 U.S.C. § 923(b). The arbitrary and capricious limitations on evidence imposed by the Scheduling Order and the amended regulations serve no truth-seeking function. Such limitations on evidence also violate my client's procedural and substantive due process rights by denying a full and fair hearing.

Ms. Elizabeth Gojmerac

July 24, 2009

Page 2

My client also objects to the Scheduling Order's advisement that the parties do not need to submit evidence to the District Director on grounds that the withholding of developed evidence interferes with the truth-seeking function. Such language in the Scheduling Order encourages "sandbagging" the administrative process by purposely withholding relevant evidence. If a proper determination, based on all of the available relevant evidence, can be made at the District Director level, a hearing before the Office of Administrative Law Judges may be unnecessary.

We further object to the Scheduling Order's shifting of the burden to a coal mine operator to prove what entity is the proper responsible operator. The burden of proof must remain on the party seeking an order. See Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994). My client reserves the right to present further evidence regarding the issues of the proper responsible operator and the length of coal mine employment.

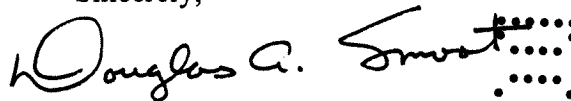
The Department of Labor's stated purpose for amending the regulations was to "streamline the adjudication of claims under the Act." 65 Fed. Reg. 80,032 (Dec. 20, 2000). The Department of Labor's comments to the amended regulation addressing the Scheduling Orders state:

In addition, the revised regulations will allow the Department to generate documents that provide a clearer and better reasoned explanation of any evidentiary evaluation made by the district director and a better understanding by the parties of their rights and responsibilities.

65 Fed. Reg. 80,032. The multi-page Scheduling Order received by my client fails to achieve that stated purpose, both in its form and in its artificial restraints on evidence.

Your consideration of these objections is appreciated.

Sincerely,



Douglas A. Smoot

cc: Ms. Patricia Fitzwater [P. O. Box 312, Quinwood, WV 25981]
Lady H. Coal Company, Inc [c/o American Mining Claims Service]
WV CWP Fund [P. O. Box 50541, Charleston, WV 25305]
Wells Fargo Disability Management

U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation
Division of Coal Mine Workers' Compensation
Greater Johnstown Tech Park
1 Tech Park Drive, Suite 250
Johnstown, PA 15901-1267



December 14, 2009

Phone: (814) 619-7777 or 1-800-347-3754

Telefax: (814) 619-7790

MINER: Jackie L Fitzwater
CLAIMANT: Patricia A Fitzwater
CLAIM NO.: XXX-XX-5934 LW C

Westmoreland Coal Company
C/O Wells Fargo Disability Mgm
PO Box 3389
Charleston, WV 25333-3389

Dear Sir/Madam:

If you agree with the Proposed Decision and Order awarding benefits, you should have an authorized officer of your organization sign and return to this Office the Agreement to Pay Benefits (Form CM-941). Payment of benefits, in accordance with the rates shown in the Proposed Decision and Order, should begin by the 15th of the month following the month for which the benefits are payable and should include any accrued benefit amount, in accordance with the rates shown in the Proposed Decision and Order.

Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by the District Director. The Proposed Decision and Order becomes effective on the thirtieth (30th) day after issuance if no party timely requests revision or a hearing.

If you wish to contest the Proposed Decision and Order, you must file a written request for revision or request a hearing within 30 days after the date of issuance of the Proposed Decision and Order. You must specify the findings and conclusions with which you disagree. The record will remain open for thirty (30) days unless extended for good cause by the District Director.

If you fail to respond within 30 days, the Proposed Decision and Order will become a final Decision and Order. All rights to further proceedings with respect to the claim shall be considered waived, except as provided in 20 CFR 725.310.

Sincerely,

DAVID M. BALMFORTH
Claims Examiner
1-800-347-3754 ext.7749
1-814-619-7749
Fax: 1-814-619-7790

cc: Patricia A Fitzwater; Westmoreland Coal Company; Self-insured thru Westmoreland Coal Company;
Douglas A. Smoot, Esquire; Lady H Coal Co Inc; Wv CWP Fund

Enclosures: CM-906, Notice of First Payment of Benefits

Director's Exh. No. 30
Consisting of 22 pages.

CM-941, Agreement to Pay Benefits

CM-971d, Benefit Rate Table

Report of Earnings by Bureau of Labor Statistics

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System

Patient: FITZWATER, Jackie L.
MRN: 01204422
DOB: 25Apr1936

Ordering Provider:

Encounter Provider: GIMPLE, LAWRENCE

Date of Service: 24Sep2008

Ordering Acct #:

Requested by: KUPIEC, JENNIFER

Report Name: Discharge Summary

Type: TRX

Admission: 08/01/2008

Discharge: 09/24/2008

Acct #: 001003828413

Attending Physician: Lawrence W Gimple, M.D.

Referring Physician:

This discharge/death summary will include the hospital course from August 24, 2008, to when the patient passed away on September 24, 2008. For details pertaining to the initial history and physical as well as other hospital course prior to this time, please refer to the discharge summary that was dictated on August 24, 2008.

Hospital course per problem below:

1. GI bleed: As indicated in the interim discharge summary, the patient has a history of intestinal AVMs and underwent several unsuccessful embolization procedures early in his hospitalization. Prior to his arrival at UVA, he had required greater than 100 units of packed red blood cells since the start of this year for this problem. Initially, the hope was that the patient would receive a tissue valve so that anticoagulation could be discontinued. However, due to the multiple issues that arose during his hospitalization, the patient was never a good surgical candidate for the procedure. The patient continued to have melanotic stools and consistently required one to two units of packed red blood cells daily to maintain an adequate hematocrit. The GI Consult Service was again re-contacted regarding any remaining therapeutic options. Capsule/pill endoscopy as well as a redo upper and lower endoscopy were discussed; however, the team felt as if even if they were able to get his current bleeding under control, it was likely that the patient would develop more AVMs and encounter continued bleeding issues in the future.

2. Chronic renal failure with progression to end-stage renal disease: The patient's creatinine was at its lowest point during hospitalization at 2.1 on August 19-August 21. Since that time, there was a gradual and steady rise to a peak of 3.6 with a BUN of greater than 100. Urine electrolytes were initially consistent with a pre-renal state; during the initial part of his hospitalization (see prior discharge summary), diuresis was the goal to maintain the patient's intravascular status; however, it was unclear at this point whether or not the patient was intravascularly depleted. The patient had a mixed response to fluid challenges and his urine output was difficult to determine due to the patient's incontinence. Right heart catheterization demonstrated pulmonary capillary wedge pressure of 25; therefore, it was thought that at that point he was not intravascularly dry. The Renal Consult Service evaluated the patient and felt that he would be an appropriate candidate to start hemodialysis. Initially, there was hope that some of the patient's intrinsic renal function would return, 16

Director's Exh. No. 16
Consisting of 25 pages.

CLAIMANT'S EXHIBIT 1: Treatment File of Dr. Lynn Smith

RECEIVED

FEB 22 2016

F.B.I. MORGANTOWN

Greenbrier Valley Medical Center

P.O. Box 497
Phone #: (304) 647-6075

Ronceverte, WV 24970
Fax #: (304) 647-6525

Pt. Name: FITZWATER, JACKIE L
DOB: 04/25/1936
Age/Sex: 69/M
Unit #: D000038770
Admit Diagnosis: CXR
Exam Date: 10/04/2005

Attending M.D.: Smith, Lynn N.
Ordering M.D.: Smith, Lynn N.
Location: DRD
Status: REG CLI
Radiology #: 38246
Account #: D00098472971

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

Exams: 000612563 XR CHEST 2 V, 000612567 XR CHEST 1 V

CHEST, SINGLE VIEW, CHEST, TWO VIEWS

CLINICAL HISTORY: SHORTNESS OF BREATH. PLEURAL THICKENING.

There is blunting of the right costophrenic angle and posterior sulcus. This may be due to a loculated effusion or area of pleural thickening. It does not appear to layer significantly in the lateral decubitus positions. Moderate cardiomegaly is identified. There is underlying COPD. There is a cardiac pacemaker.

IMPRESSION: LOCULATED EFFUSION VERSUS PLEURAL THICKENING.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT13264

** Electronically Signed by Heather Rose M.D. on 10/05/2005 at 0832 **
Reported and Signed by: Heather Rose, M.D.

CC: Lynn Smith, M.D.

Dictated Date/Time: 10/04/2005 (0000)

Technologist: Carol M Creasman RT(R)

Transcribed Date/Time: 10/04/2005 (1804)

Transcriptionist: PMTKAC

Orig Print D/T: S: 10/05/2005 (0833) Batch No: 5974

PAGE 1

Lynn Smith, M.D.

RECEIVED OCT 06 2005

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.301

UNIT #: D000038770

ADMISSION DATE: 09/06/05

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater is a 69 year old who was recently hospitalized with congestive heart failure and some ataxia. He had full workup at that time and felt that it was most likely just due to his multi-system problem including his diabetes, neuropathy. He went home, doing quite well on Friday. The day of admission he was up walking and actually said he felt good. According to him he basically did not have any major complaints but he fell backwards and was not able to get up. He was extremely weak. His daughter called. They were not able to get him up and they brought him in by ambulance. He did not have any loss of consciousness. He did not have syncope. Did not have pain. Did not have palpitations. He basically said that he lost his balance and fell but he could not get up. Workup found that he had become anemic with hemoglobin of 7.6 with heme positive stool. His INR was elevated at 7. It appeared this gentleman has chronic atrial fib with a prosthetic valve and is on long-term anticoagulation. Normally runs an INR about 3 1/2 to 4. He denies mistaking any of his medication. Denied any dietary changes. He has not been on any recent antibiotics.

PAST MEDICAL HISTORY: He has a known prosthetic aortic valve. He has a history of restrictive pericarditis, pneumoconiosis, hypothyroidism and hypertension. He also has had two episodes of toxic shock syndrome associated with acute renal failure. He has known chronic atrial fibrillation. He has a history of diabetes Type 2 for which he has been on oral medication, severe peripheral neuropathy.

PAST SURGICAL HISTORY: He has had a prosthetic aortic valve placed and a permanent pacemaker in 2003. He has had bilateral carpal tunnel surgery, cholecystectomy. He has also had one episode of pericardial stripping. He also had a circumcision for a paraphimosis.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS: Include nebulizers, Demadex, Aldactone, Glyburide, Synthroid, Lanoxin, Allopurinol, Flomax, Neurontin, Nexium, Proscar and Reglan.

SOCIAL HISTORY: He is married, lives at home with his wife. He is a retired coal miner. He has a longstanding history of smoking. He still cheats a little bit and smokes occasionally. No significant alcohol.

FAMILY HISTORY: His mother died of old age. She was a known diabetic. Father died with a CVA. There is a positive family history for both diabetes and cardiac disease.

REVIEW OF SYSTEMS: His appetite has been good. His weight is actually down to 200 which for him is quite good. He denied any difficulty in swallowing. He has some

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

hearing problems. He has had no cough or sputum production or hemoptysis. No epistaxis. He denies any abdominal pain although he had had some nausea periodically. No diarrhea. Stool is always black because he had been on iron therapy for some time. He denies any GU or GI symptoms at this time. He had the numbness and weakness in his legs with occasional pain. He has gait problems with balance issues. At this time he was weak but could not get up but there was not anything focal. No loss of consciousness or syncope. Skin had no rashes or excessive bruising.

PHYSICAL EXAMINATION: He is alert and oriented. Blood pressure was 100/70 which was normal for him. Pulse was in the 70's and irregular. He was afebrile with O2 sat of 98%.

SKIN: No unusual rashes or ecchymotic areas. There was no evidence of any trauma to head, back or hip.

HEENT: His pupils were equal and reactive. Sclerae and conjunctivae unremarkable. There is some mild pallor. Posterior pharynx was clear.

NECK: Good carotid upstrokes without audible bruits. Thyroid was not enlarged.

LUNGS: Clear at this time with no wheezes or rales.

CARDIAC: Irregular rate and rhythm with Grade II murmur and a valve click which was unchanged.

ABDOMEN: Soft, non-tender. Bowel sounds were normoactive. He is moderately obese. Stool was black and heme positive.

EXTREMITIES: Warm. He has trace peripheral edema, chronic stasis changes with his lower extremities with adequate pulses.

NEUROLOGIC: There is no focal motor change, diffusely weak but he had symmetrical motor strength bilaterally, absent reflexes in his legs.

LABORATORY DATA: His hemoglobin was down to 7.6 with otherwise normal findings. His Dig. level was therapeutic. Electrolytes showed BUN of 62 with creatinine of 1.9. Sodium always low at 128. His pro time was elevated at 7.

IMPRESSION:

1. Gastrointestinal bleed.
2. Anemia secondary to #1.
3. History of prosthetic valve.
4. Diabetes Type 2.
5. Peripheral neuropathy with ataxia.

PLAN:

He is put in the Unit at this time. Will give him Vitamin-K, 2.5 now. We cannot reverse him because of his valve. I have discussed with Surgery the need for EGD eventually. He is going to be transfused two units of packed cells and when

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

stabilized will be placed on the floor and will wait for his INR to return to an acceptable range and will determine if it has to be reversed any, placed on anticoagulation pending on his bleeding status.

Lynn N. Smith, M.D.

D: 09/07/05 0642

T: 09/07/05 0708

MAF

PMT, Inc. #06043

CC:

RECEIVED SEP 1 2005

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
ROOM #: D.302

DOB: 04/25/36
UNIT #: D000038770

ADMISSION DATE: 08/30/05

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: 69 year old male with a history of a multitude of problems including congestive heart failure, status post prosthetic valve. He has a history of diabetes with severe peripheral neuropathy. He has a history of chronic atrial fibrillation, restrictive pericarditis, diabetes. He has not done well over the last several weeks according to his family. He has had increasing shortness of breath, PND, had to use more oxygen. He has had increase in swelling. His appetite has been poor. He has had some intermittent nausea throughout this period. He has also become ataxic. According to him he can't walk without running into the walls. He has tended to fall backwards. He has even fallen off chairs. He has had a history of some gait disturbance in the past but nothing to this extent. He denies any headaches, recent head injuries nor has he had any significant motor abnormalities to the best of his knowledge. This has been a progressive process over the last two weeks to where now he is almost nonambulatory.

PAST MEDICAL HISTORY: He has atrial fibrillation. He has a known prosthetic aortic valve. He has a history of restrictive pericarditis. He has pneumoconiosis, hypothyroidism and hypertension. He also has had a history of toxic shock syndrome secondary to Strep infection and has a history of acute renal failure associated with such.

PAST SURGICAL HISTORY: He has had pericardial stripping. He has had a prosthetic aortic valve placed and a permanent pacemaker in 2003, bilateral carpal tunnel surgery and he has had a cholecystectomy in the past.

ALLERGIES: He has no major drug allergies.

MEDICATIONS: His medications are numerous and include nebulizers, coumadin, Nexium, Neurontin, Flomax, allopurinol, Lanoxin, Synthroid, glyburide, Aldactone, Demadex, Proscar and Reglan.

SOCIAL HISTORY: He is married, lives at home with his wife. He is a retired coal miner. He used to smoke heavily. He still does occasionally smoke according to the family although he denies it. No significant alcohol.

FAMILY HISTORY: Mother died, was a known diabetic and she died really at an old age in her late 80's. Father died with a stroke. There is positive family history for both heart disease, diabetes and hypertension. No malignancies.

REVIEW OF SYSTEMS: The appetite has not been good recently. He has actually lost about 15 pounds. He has no headache or visual disturbances. No difficulty in swallowing. He has had the cough and shortness of breath per history of present illness with no hemoptysis or sputum production. No chest pains or palpitations. He

RECEIVED SEP 01 2005

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

has had nausea with occasional episode of vomiting and dry heaves. No diarrhea. No hematochezia or melena. His joints have had some minimal discomfort but he has not had any significant pain or swelling. He has had the gait disturbance in the past with probable cerebellar dysfunction and that has gotten much worse recently as per history of present illness. He has known degenerative back disease with minimal arthritis.

PHYSICAL EXAM: The patient is alert. He has a very depressed affect. He is concerned that he has just felt so bad now for some time. His blood pressure is only about 100/50, temperature 99, pulse 90 and irregular. His weight is 216#. His sclerae and conjunctivae are unremarkable. Pupils were equal. TM's clear. He has clear posterior pharynx. No oral lesions. Good carotid upstrokes without bruits. His lungs show decreased breath sounds on the right compared to the left with some scattered rales. He has irregular rate and rhythm with a Grade II murmur and his valve click which is unchanged. His abdomen is protuberant, bowel sounds active. No palpable fluid wave or organomegaly or tenderness. He has 1+ or mildly worse pitting edema with chronic stasis changes and a small little break ulcer of about 1/2 cm. on the left lower leg with some serous drainage. He has decreased sensory bilaterally in his feet. Neurologically his cranial nerves appear to be intact. He has absent reflexes in his lower extremities. He has decreased sensory and light touch consistent with moderate to severe neuropathy. Motor strength tested in lower and upper extremities is relatively equal and about 4-5 in strength. He is ataxic. This gentleman even tried to fall off the exam table while we were examining him. He tends to fall backwards. He does not have nystagmus or truncal ataxia at this time.

IMPRESSION:

1. Congestive heart failure
2. Ataxia
3. Diabetes
4. Status post prosthetic valve

PLAN: Admit him at this time. We will have routine labs, CT of his head, neurology consult. He will have more aggressive diuresis at this time and management of congestive failure.

Lynn N. Smith, M.D.

D: 08/31/05 0738
T: 08/31/05 0809
JNM PMT, Inc. Job #: 04346

RECEIVED SEP 01 2005

Patient Name

Jackie Fitzwater

Age

Date

8/30/05

Lynn N. Smith, M.D.

Doris A. Ragsdale, M.D.

John W. Galbreath, M.D.

Chief Complaint

Felt Bad x 2 weeks

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change

Fever

Chills

Sweats

HA

Weakness

Appetite

GENITOURINARY

Polyuria

Dysuria

Nocturia

Vag discharge

LMP

CARDIOVASCULAR

Chest Pain

SOB

Palpitation

Edema

HTN

PND

Orthopnea

MUSCULOSKELETAL

Arthralgia

Myalgia

Stiffness

Joint Swelling

Injury

FAMILY HISTORY**PHYSICAL EXAM:**

Ht

Wt

*217*BP *120/50*

Pulse

84 Irregular

Temp

Resp

EXAM**LAB**

AIC

JACKIE FITZWATER**8/30/05**

S: Jackie just continues to worsen with increasing failure and he has become grossly ataxic at this time, etiology is unclear.

EXAMINATION: Gross ataxia and questionable truncal ataxia. He is being admitted to the hospital at this time for further evaluation and treatment.

Lynn N Smith, MD/NM/aw

Extremities

Skin

Neuro

Psych

GYN/Rectal

IMPRESSION:

TSH

UA/CULT

URIC ACID

VAG CULT

ANEMIA PANEL

HEP PANEL

LAB RESULTS:**PLAN:**

NEW DATE Plus Low Sched

FAX NO. 3046473403

P. 04

4BBRUN DATE: 10/13/04

RUN TIME: 1620

RUN USER: OSBALDE

GREENBRIER VALLEY MEDICAL CENTER

202 MAPLEWOOD AVENUE RONCEVERTE, WV 24970

PCI User: OSBALDE Lab Database: LAB.COCGY

PATIENT: FITZWATER, JACKIE L

ACCT #: D00098404659 LOC: DLB

U #: D000038770

AGE/SX: 68/M

ROOM:

REG: 10/13/04

REG DR: Smith, Lynn N.

DOB: 04/25/36

BED:

DIS:

STATUS: REG CLI

TLOC:

Specimen: 1013:GY:CG00022R COMP Collected: 10/13/04-1345 Received: 10/13/04-1525

Test	Normal	Abnormal	Flag	Reference	Site
COAGULATION					
PT		18.7	H	11.0-13.0 SECONDS	
PT PATIENT		2.51	H	<1.3	
INR					
Indications:					
Condition			Recommended INR range		
Prophylaxis of venous thrombosis			2.0-3.0		
Treatment of venous thrombosis and pulmonary embolism			2.0-3.0		
Prevention of systemic embolism, including Acute Myocardial Infarction			2.0-3.0		
Tissue heart valves and valvular heart disease			2.0-3.0		
Prosthetic heart valves			2.5-3.5 +/- low dose aspirin		
Prevention or recurrent thrombosis in patients with antiphospholipid antibodies			2.5-3.5		

N
 480
 per JTB
 HCP + pl.
 called
 10/14/04

Patient: FITZWATER, JACKIE L

Age/Sex: 68/M

Acct#D00098404659 Unit#D000038770

American HomePatient Respiratory Care

Box 1850 Lewisburg, WV. 24901

Study date 06/20/05
Doctor: LYNN SMITHStarting Time: 23:16
Ending Time: 07:17Jackie Fitzwa
ID#:

RECORD OF OXIMETRY

Comments: WITH O/ 2 AND C-PAP ON

RECORDING TIME: 08:01:08	HIGHEST PULSE: 224	HIGHEST SpO2: 98%
EXCLUDED SAMPLING: 00:00:16	LOWEST PULSE: 70	LOWEST SpO2: 76%
TOTAL VALID SAMPLING: 08:00:52	MEAN PULSE: 89	MEAN SpO2: 92.4%
	1 S.D.: 7.4	1 S.D.: 4.1

TIME WITH SpO2<90: 2:07:24, 26.5%	TIME WITH SpO2 >=90: 5:53:28, 73.5%
TIME WITH SpO2<80: 0:01:16, 0.3%	TIME WITH SpO2 >=80 & <90: 2:06:08, 26.2%
TIME WITH SpO2<70: 0:00:00, 0.0%	TIME WITH SpO2 >=70 & <80: 0:01:16, 0.3%
TIME WITH SpO2<60: 0:00:00, 0.0%	TIME WITH SpO2 >=60 & <70: 0:00:00, 0.0%
TIME WITH SpO2<88: 1:03:20, 13.2%	

THE LONGEST TIME WITH A SATURATION LESS THAN 88 WAS 00:09:20, WHICH STARTED AT 04:53:42.

A DESATURATION EVENT WAS DEFINED AS A DECREASE OF SATURATION BY 4 OR MORE.

NO EVENTS WERE EXCLUDED DUE TO ARTIFACT.

THERE WERE 15 DESATURATION EVENTS OVER 3 MINUTES DURATION.

THERE WERE 57 DESATURATION EVENTS OF LESS THAN 3 MINUTES DURATION DURING WHICH:

THE MEAN LOW WAS 84.3%. THE MEAN HIGH WAS 90.6%.

THE NUMBER OF THESE EVENTS THAT WERE:

> 0 & <10 SECONDS: 0	> 0 SECONDS: 57
=>10 & <20 SECONDS: 9	=>10 SECONDS: 57
=>20 & <30 SECONDS: 16	=>20 SECONDS: 48
=>30 & <40 SECONDS: 3	=>30 SECONDS: 32
=>40 & <50 SECONDS: 5	=>40 SECONDS: 29
=>50 & <60 SECONDS: 4	=>50 SECONDS: 24
=>60 SECONDS: 20	=>60 SECONDS: 20

THE MEAN LENGTH OF DESATURATION EVENTS THAT WERE >=10 SEC & <=3 MINS WAS: 55.4 SEC.

DESATURATION EVENT INDEX (EVENTS >=10 SEC PER SAMPLED HOUR): 7.1

DESATURATION EVENT INDEX (EVENTS >= 0 SEC PER SAMPLED HOUR): 7.1

PROFOX version: Respironics 02/99
Oximeter: Respironics 920M memory, 4 second resolution.

Phone 645-3207

AGE

DATE _____

REFILL

Not formal oxime, with
 $\text{O}=\text{C}(\text{Ph})$

M.D.

night while asleep. I was with him
person.

Instructions are as follows:

1. Place probe on finger. (If applicable, wear wrist band)
2. Turn base unit on.
3. Go to sleep (if you wake up in middle of night, continue to wear oximeter)
4. When you awake in morning, take probe off finger and turn unit off.
5. Bring oximeter in before 9:00am

Date _____

Address

City

State

Zip Code

Telephone Number



RL 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

[illegible]

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 10/04/04

DISCHARGE DATE: 10/09/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Paraphimosis.
2. Pneumoconiosis.
3. Chronic obstructive pulmonary disease.
4. Coronary artery disease.
5. Status post valvular replacement.
6. History of restricted pericarditis.
7. Diabetes mellitus type 2 on oral agents.
8. Hypertension.
9. Hypothyroidism.

PROCEDURE: Circumcision.

DISCHARGE MEDICATIONS: The patient will be discharged home and resuming his regular home medications. He will be kept on Lovenox 100 mg subcu. q. 12 hours.

DISCHARGE INSTRUCTIONS: Followup appointment with Dr. Moshy in one week and followup with me in two weeks. The patient will have protime drawn on Tuesday. He will continue with his regular Coumadin dose at this time.

SUMMARY: This is a 68 year old with multiple medical problems on chronic anticoagulation because of a prosthetic valve. He had a paraphimosis with recurrent infections and obstruction. He was brought in at this time for surgical correction. Because of his long term anticoagulation, this had to be reversed and he was placed on Lovenox until such time as the surgery could be performed. His Coumadin had been discontinued approximately two days prior to his hospitalization and his INR was down to 2.3 on admission.

HOSPITAL COURSE: He was admitted and started on Lovenox at 100 mg subcu. q. 12 hours. His regular meds were continued at this time. Basically, within the next 48 to 72 hours, his labs came back down into a normal range where he could then undergo surgical correction. He underwent a circumcision without difficulty and tolerated it well. He did not have any major problems with pain or infection postop. He was

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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 10/04/04 DISCHARGE DATE: 10/09/04
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

continued with his Lovenox and restarted on his Coumadin the day of his surgery. The day after his surgery, he was up and ambulating and feeling well. Arrangements were made for him to go home and would start on Lovenox at home subcu. until such time as he was therapeutic again. We will have his protime drawn in approximately 48 hours. He was given a loading dose of 10 mg the first two days and then we will return to his baseline dosing.

Lynn N. Smith, M.D.

D: 10/23/04 0852
T: 10/24/04 1521
VGC

PMT, INC. #12507

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GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.322 UNIT #: D000038770
ADMISSION DATE: 03/04/04
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: Bleeding from penis.

HISTORY OF PRESENT ILLNESS: Patient states that the bleeding began two days ago and has progressively gotten worse. He has a long history of paraphimosis and has had repeated infections, reportedly yeast infections of the foreskin and glans. He was scheduled last month to be circumcised by Dr. Moshy but was unable to keep that appointment due to a cardiac cath in Charlottesville. He reports having a rash on his penis for the past month for which he has used an antifungal cream and also reports bright red blood per urination and blood stained undergarments. He also reports periods of weakness and dizziness but denies any recent burning with urination, back pain, flank tenderness. He was also in the hospital earlier this week due to anemia and CHF.

PAST MEDICAL HISTORY:

1. History of hypertension.
2. Chronic A fib.
3. Prosthetic aortic valve.
4. History of restrictive pericarditis.
5. History of sleep apnea for which the patient uses a CPAP at night.
6. Diabetes mellitus type 2 insulin dependent.
7. COPD.
8. History of smoking.
9. History of black lung disease.
10. Hypothyroidism on Synthroid.
11. History of GI bleeds and gastritis.
12. History of toxic shock syndrome secondary to a strep infection due to a cellulitis in his leg.
13. Paraphimosis

SURGICAL HISTORY:

1. Pacemaker placement September 2003.
2. Aortic valve replacement '98.
3. Bilateral carpal tunnel surgery '94.
4. Pericardial stripping done twice in '98 and '99.
5. Cholecystectomy 30 years ago.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS: Neurontin 400 q.i.d., Zaroxolyn 5 mg qd, Nexium 20 mg qd, Flomax 0.4 mg b.i.d., Allopurinol 100 mg qd, Coumadin 1 mg qd, Digoxin 0.125 mg qd, Synthroid 200 micrograms qd, Glyburide 5 mg 1/2 a pill b.i.d., Spironolactone 50 mg, Torsemide 100 mg b.i.d., Proscar 5 mg qd.

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GREENERIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

SOCIAL HISTORY: Patient has been married for 48 years. Lives at home with his wife. Has a long history of cigarette smoking which he has cut down to reportedly one or two cigarettes a day. He also worked as a coal miner in the past.

FAMILY HISTORY: Father died at 80 years of age of a stroke. Mother died 80 years old of diabetes. Positive family history of diabetes, heart disease, hypertension.

REVIEW OF SYSTEMS: Patient confirms the following symptoms:

1. Difficulty swallowing with regurgitation and stasis of food.
2. Decreased visual acuity with a history of cataracts which he has been advised by Dr. Light will need to be removed.
3. Unsteady gait for which he uses a walker to ambulate at home.
4. Nasal drainage clear in nature.
5. Confirms bright red blood coming from the penis during urination and a rash which has been present on his penis for the past month.
6. Patient confirms constipation.
7. Patient denies any headache, any decrease in hearing, any numbness or loss of strength on either side of his face. Denies any palpitations, chest pain or diaphoresis. Denies any shortness of breath or cough. Patient denies any nausea, vomiting or diarrhea. Patient denies any burning with urination. Patient denies any loss of muscle strength of his extremities or loss of sensation.

PHYSICAL EXAMINATION: Orthostatic blood pressures: Lying 87/37, pulse 91, respirations 16; sitting blood pressure 86/51, pulse 90, respirations 16; standing blood pressure 81/46, pulse 90, respirations 16. PERLA. BOMI. Cranial nerves II-XII are grossly intact. Gag reflex was present. There was no thyromegaly. There was no cervical adenopathy. Muscle strength of the extremities was 5/5 and sensation was intact. Gait was guarded but patient was able to ambulate on his own and was able to stand without becoming dizzy. Heart was irregular rate with a grade V systolic murmur best heard over the aortic auscultation area. There was 1+ pitting edema of the extremities. No JVD was noted. Slight rhonchi was heard when listening to the right upper lobe of the lung which was cleared by coughing. Bowel sounds were present x 4 without areas of tenderness or masses noted. Pulses in the upper extremities 2/4; pulses in the lower extremities could not be felt due to swelling. Both feet were warm and sensation was intact. Exam of the genitalia revealed paraphimosis of the foreskin with rash noted on the glans and dried blood noted on the urethral opening. Also, patient has an incisional scar he reports his cath done two weeks ago. Reportedly had some bleeding from that area a little bit earlier tonight at home and there was piece of gauze in place. Rectal exam revealed external hemorrhoids.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

LABORATORY: PT 20.7, INR 3.09, PTT 38.3, WBC 8.8, H&H 8.3/27.5. Platelets 272. RDW 21.1, TSH 3.67, digoxin 1.1. UA revealed a large amount of blood with 30-50 RBCs seen.

IMPRESSION:

1. Hematuria.
2. Anemia with hypotension.
3. CHF with diastolic dysfunction.
4. Pulmonary hypertension.
5. History of hyponatremia.
6. History of previous GI bleeds.
7. A fib with pacer in place.
8. Prosthetic aortic valve.
9. Hypothyroidism.
10. Diabetes mellitus type 2 insulin dependent.
11. History of prerenal azotemia.
12. History of gout.

PLAN: We will admit the patient to the hospital, consult Dr. Moshy. We will transfuse 2 units packed red blood cells and instruct nurses to apply pressure during dressings to the right groin. We are going to order stool test for occult blood, PT in the a.m. and we are still going to add a CBC and BMP to the current tests. We are going to instruct respiratory therapy to put the patient on CPAP for sleep at night and order a noncontrast CT of the abdomen and pelvis tonight.

Lynn N. Smith, M.D.

Dictated by Thomas Gannon, MS-IV

D: 03/04/04 1850
T: 03/04/04 2138
WKG

cc:

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GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.303 UNIT #: D000038770
ADMISSION DATE: 02/29/04
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

PATIENT PROFILE: This is a 67 year old gentleman with a history of restricted paracarditis, diastolic dysfunction, congestive heart failure.

CHIEF COMPLAINT: Falling and weakness.

HISTORY OF PRESENT ILLNESS: Ms. Fitzwater just got out the University of Virginia approximately three days ago after a fairly long stay. He had a major workup concerning his cardiovascular system. He had a repeat cardiac catheterization. He had outlet studies and basically was found that he had overall pretty good LV function at about 55% with evidence of diastolic dysfunction, pulmonary hypertension. Primary etiology was congestive heart failure. He got up to go to the bathroom this even, became dizzy, fell and sustained a laceration. Evaluation of him at this time shows that he is hyponatremic with sodium of 120. BUN is 84 with a creatinine of 2. Hemoglobin 7.2. He does have heme positive stools with a prior history of GI bleeding in the past.

PAST MEDICAL HISTORY: He has a past medical history of hypertension, history of chronic atrial fibrillation, prostatic valve, restrictive pericarditis, sleep apnea, type-2 diabetes, COPD, hypothyroidism, prior history of some GI bleeding which I believe was due predominantly to gastritis. He also had at least two episodes of toxic shock secondary to strep infections due to cellulitis in his leg. He has never had endocarditis.

PAST SURGICAL HISTORY: He's had a pacemaker placed. He also had valve replacement. Bilateral carpal tunnel syndrome. He's had a pericardial stripping and a cholecystectomy. He has a known mechanical aortic valve.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS: His current medications include Synthroid, Lanoxin, Nexium, Lasix, Zaroxolyn, Alopurinol, Aldactone, iron supplementations, Coumadin. He is also on Lovenox at this time. Glyburide.

SOCIAL HISTORY: He is married and lives at home with his wife. He is a retired coal miner. He has a longstanding history of cigarettes and is actually still smoking a few intermittently before going into the hospital. He was a heavy drinker in the past but has not had any alcohol in a number of years.

FAMILY HISTORY: His father died with a stroke, his mother died with diabetes. There is a family history of diabetes, heart disease and hypertension.

REVIEW OF SYSTEMS: His appetite has actually been pretty good. He has had no visual

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

because of the persistent blood loss. Will hold his diuretics for now with a very low dose of sodium replacement because of hyponatremia. We will try to ambulate him in a day or two and see if his orthostasis resolves.

Lynn N. Smith, M. D.

D: 02/29/04 0239
T: 02/29/04 0721
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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 02/29/04

DISCHARGE DATE: 03/02/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Anemia, chronic, questionable blood loss.
2. Orthostatic hypotension secondary to volume deficiency.
3. Restricted paracarditis with diastolic dysfunction.
4. Diabetes mellitus.
5. Status post prostatic valve.
6. Hyponatremia and electrolyte disturbance.

DISCHARGE MEDICATIONS: The patient will be discharged home and continue with his current medicines. Coumadin will be increased 8 mg a day, Lotrisone Cream 30 grams to groin prn, Lovenox 100 mg subcu every 12 hours until therapeutic INR. Continue with iron tablets three times a day, Vitamin C 250.

DISPOSITION: Patient is discharged home in care of the family. We will have a protime drawn Friday and a BMP drawn Friday as well.

SUMMARY: This is a 67 year old gentleman with a very complicated history. He'd just returned from Charlottesville after a long stay where he was found to basically have evidence of congestive failure, pulmonary hypertension with diastolic dysfunction. He had been extremely diuresed over there and presented at this time with increasing dizziness, weakness and falling. He was found to be hyponatremic with a sodium of 120, BUN 84, creatinine 2. Hemoglobin was 7.2. He'd had a history of GI bleeding in the past, but had had a full workup in the last year or so. We don't know if he had any evidence of any active bleeding while in Charlottesville.

PHYSICAL EXAM: He had a blood pressure of 90 sitting and he dropped to 70 when he stood. He was in atrial fib with a rate in the 70s. He was pale. **HEENT** - Otherwise unremarkable. **HEART** - Atrial fib rhythm with no significant murmurs and a very prominent valve click. **RECTAL** - Stool was minimally hemepositive and yellow. **EXTREMITIES** - No significant peripheral edema. **NEURO** - No focal neurological deficits.

HOSPITAL COURSE: He was admitted at this time and we transfused him 3 units of packed cells. We kept him on Lovenox and his Coumadin. He actually felt much better. As soon as we got him hydrated and got some blood on board, his labs improved. His hemoglobin improved and he felt much better. We consulted Surgery who really didn't want to put him through another evaluation since he had just been

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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 02/29/04

DISCHARGE DATE: 03/02/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

through one recently. We know he has some history of chronic blood loss due to some diverticular disease and it may have been that with all the testing he had at Charlottesville, that they just didn't monitor his hemoglobin prior to discharge. At this time, we are going to discharge him home and continue with his iron supplementations, and hopefully this will help correct his anemia and we will monitor it very closely. If further bleeding occurs, or recurrent anemia occurs, then we will have to consider re-evaluation of GI tract.

Lynn N. Smith, M.D.

D: 04/03/04 0859

T: 04/05/04 0939

VGC

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***** DISCHARGE SUMMARY *****

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UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE
Med Rec: 120-44-22
Admission: 02/18/2004
Discharge: 02/26/2004
Date of Birth: 04/25/1936
Acct.#:001002942496

Attending Physician: Michael Ragosta, M.D.
Referring Physician:

PRIMARY DISCHARGE DIAGNOSIS: Congestive heart failure.

SECONDARY DIAGNOSIS:

1. Severe aortic stenosis status post aortic valve repair.
2. History of constrictive pericarditis.
3. Atrial fibrillation.
4. Hypertension.
5. Chronic obstructive pulmonary disease.
6. Sleep apnea.
7. Diabetes mellitus.
8. Iron deficiency anemia.

PROCEDURE PERFORMED: On February 23, 2004, the patient was taken for cardiac catheterization. This revealed an ejection fraction of 52%. He had mild luminal irregularities. Normal prosthetic aortic valve. A PA pressure of 53/21 with a mean of 35. A mean pulmonary wedge pressure of 26. Pulmonary vascular resistance of 1.27 Woods and no evidence of a constrictive disease. Mild LV dysfunction.

REASON FOR ADMISSION: This is a 67-year-old white male with a history of St. Jude valve replacement for severe aortic stenosis in 1998, which later resulted in restrictive pericarditis in 2000. He has been hospitalized several times over the past year with dyspnea on exertion and increased lower extremity edema, which was treated with diuresis for congestive heart failure. He presents today as followup to a recent admission on February 1, 2004 at an outside hospital for a CHF exacerbation. He is admitted with a plan to do a right and left heart cath to work up causes of his recurrent CHF exacerbations.

Presently, the patient reports baseline shortness of breath and relatively improved lower extremity edema. He denies any chest pain or diaphoresis. He has had an upper respiratory infection for the past week, which is improving with cefuroxime.

PAST MEDICAL HISTORY:

1. Femoral neck fracture.
2. COPD.
3. Sleep apnea.
4. Diabetes mellitus, type 2.
5. Gout.
6. BPH.
7. Hypothyroidism.

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Page 1 of 4

From: Health Information

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UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE
Med Rec: 120-44-22
Admission: 02/18/2004
Discharge: 02/26/2004
Date of Birth: 04/25/1936
Acct. #: 001002942496

8. Hypertension.
9. Atrial fibrillation.
10. History of severe aortic stenosis, requiring aortic valve replacement in 1998 with a St. Jude valve.
11. History of constrictive pericarditis in 2000, which was treated with pericardial stripping.
12. Status post dual-chamber pacemaker for bradycardia in 2002.
13. A transthoracic echocardiogram in July 2003 showed a normal ejection fraction, left ventricular hypertrophy, and decreased right ventricular function.
14. A MUGA scan in February 2004 revealed an ejection fraction of 55%.

ALLERGIES: Ace inhibitor.

HOME MEDICATIONS:

1. Proscar.
2. Lasix.
3. Coumadin.
4. Synthroid.
5. Neurontin.
6. Nexium.
7. Zaroxolyn.
8. Flomax.
9. Spironolactone.
10. Allopurinol.
11. Reglan.
12. Digoxin.
13. Glyburide.
14. Lexapro.
15. Cefuroxime.

HOSPITAL COURSE: The patient was admitted to the CCU Service for right and left heart cath. On admission, his vital signs were stable, and he was at his baseline 98% on 3 L of oxygen. His admission labs were remarkable for a creatinine of 2.1 and a BUN of 47, which is his baseline. Hyponatremia with a sodium of 126. He was anemic with a hematocrit of 26.2. On further questioning, it was revealed that the patient has questionable adherence to his medication regimen. In addition, he admits to not using his CPAP on a regular basis for his obstructive sleep apnea. Therefore, in the hospitalization, the patient was put on a heparin drip, and his Coumadin was discontinued in anticipation of his catheterization. He was placed back on his previous home medications. He was encouraged to use his CPAP on a regular basis at night. The patient's anemia was worked up and revealed what appeared to be iron deficiency anemia, for which he was placed on iron replacement. He was also evaluated in the Pulmonary lab with PFTs, which confirmed more of a restrictive process. However, he was continued on his nebulizers. It was remarkable how the patient

Page 2 of 4

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UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE
Med Rec: 120-44-22
Admission: 02/18/2004
Discharge: 02/26/2004
Date of Birth: 04/25/1936
Acct.#: 001002942496

Improved in the hospital just being kept on his home medications. He diuresed very well, usually 1 to 2 L a day, without any additional diuretics. On the 23rd, the patient was taken for cardiac catheterization, with the results as above. Following this, he was started back on his Coumadin. He had transient increase in his BUN following this procedure, which was thought to be too aggressive diuresis, and his Zaroxolyn dose was decreased. The remainder of his hospitalization was just awaiting his INR to once again become therapeutic so that he could be taken off the heparin drip. Once the patient's renal failure resolved, he was felt a candidate for anticoagulation with Lovenox and was discharged home on the 27th.

DISCHARGE MEDICATIONS:

1. Allopurinol 100 mg p.o. q.d.
2. Digoxin 0.125 mg p.o. q.d.
3. Combivent two inhalations q.4h.
4. Docusate sodium 100 mg p.o. q.d.
5. Lexapro 10 mg p.o. q.d.
6. Nexium 20 mg p.o. q.d.
7. Ferrous sulfate 325 mg, one p.o. t.i.d. with meals.
8. Finasteride 5 mg p.o. q.d.
9. Lasix 80 mg p.o. b.i.d.
10. Lasix 20 mg p.o. b.i.d.
11. Neurontin 400 mg p.o. q.d.
12. Glyburide 2.5 mg p.o. q.d.
13. Regular insulin on a sliding scale.
14. Synthroid 0.2 mg p.o. q.d.
15. Synthroid 0.025 mg p.o. q.d.
16. Reglan 10 mg p.o. t.i.d. with meals.
17. Spironolactone 50 mg p.o. q.d.
18. Coumadin 7.5 mg p.o. q.h.s.
19. Metolazone 5 mg p.o. b.i.d.

DISCHARGE INSTRUCTIONS: The patient was instructed to adhere to a heart-healthy consistent-carbohydrate diet. He was instructed to slowly increase his activities as tolerated. The patient was instructed to weigh himself on a daily basis and contact his physician if his weight went up more than 3 or 4 pounds. Home health was arranged to follow the patient's INR at home.

Dictated and Dated by:

OFFICE COPY FOR: Lynn Smith, M.D.,

Page 3 of 4

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE
Med Rec: 120-44-22
Admission: 02/18/2004
Discharge: 02/26/2004
Date of Birth: 04/25/1936
Acct.#: 001002942496

Rebecca M Shumate, M.D.
Resident
Internal Medicine

Signed and Dated by:
Electronically Authenticated by
Michael Ragosta, M.D. 10/01/2004 13:45
Michael Ragosta, M.D.
Attending
Internal Medicine
Box 800158
Charlottesville VA 22908
VOICE: 9242420 FAX: 9820901

RS/mac Job: 000874051 D: 08/18/2004 1:35 P T: 08/18/2004 2:48 P

cc: Michael Ragosta, M.D.
Box 800158
Charlottesville VA 22908

Lynn Smith, M.D.
Rt 2 Box 171
Lewisburg WV 24901

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Page 4 of 4

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/26/04

DISCHARGE DATE: 02/01/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSES:

1. Congestive heart failure, acute, secondary to acute diastolic dysfunction
2. Chronic obstructive lung disease.
3. Hyponatremia.
4. Status post valve replacement.
5. Diabetes mellitus, type on oral agents.
6. Status post cardiac pacemaker.
7. Hypothyroidism.

DISCHARGE MEDICATIONS: Aldactone, 75 mgs po bid, Demadex, 100 mgs bid, Lanoxin, .125, Glyburide, 5 mgs bid, Coumadin, 8 alternating with 7 mgs, Reglan, 10 mgs 30 minutes ac, Synthroid, .125 per day, Flomax, .4 per day, Proscar, 5 mgs a day, Allopurinol, 300 mgs a day.

DISPOSITION: The patient is discharged home, will have a followup appointment in approximately one week. We will hold all potassiums, Metaglip and Zaroxolyn at this time. He will be placed on a low sodium 1800 calorie ADA diet, no smoking, activity will be as tolerated. Dietary information is provided.

SUMMARY: This is a 67 year old gentleman who presented with increasing shortness of breath and dyspnea on exertion. He has known restrictive cardiomyopathy after having a valve replaced and subsequent pericarditis. He is post pericardial stripping. He presented with about a 14 pound weight gain over the last week since his last discharge. His chest x-ray on presentation shows a moderate right sided effusion. INR was therapeutic at 3.2. Electrolytes were unremarkable with a mild low sodium at 131 with potassium of 3.1. BUN was 33 with a creatinine of 1.8.

His exam showed that his blood pressure was good at 112/66. HEENT was unremarkable. He had decreased breath sounds in the right with a few faint rales at the left. He had the valvular click with is irregular atrial fib which was controlled. He had 2+ pitting edema with some chronic stasis dermatitis.

HOSPITAL COURSE: Patient was admitted, was started back on IV diuresis. We did change him over to Aldactone at 50 mgs a day and subsequently adjusted it upward to try to help maintain his potassium. This did work well and with no potassium supplementation potassiums remained in the 3.5 to 4.5 range. MUGA scan was performed which was unremarkable, actually showed good LV function. EF was noted to be about 55%.

With diuresis and adjustment in medication his effusion improved, his shortness of breath improved and his weight went down. At this time he is being discharged home

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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/26/04

DISCHARGE DATE: 02/01/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

in improved condition and we will try different combinations for his diuresis which is predominantly due to his right sided failure and his restricted pericarditis.

Lynn N. Smith, M.D.

D: 02/14/04 0825

T: 02/15/04 1733

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PMT, Inc., Job #07821

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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/19/04

DISCHARGE DATE: 01/22/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive failure, primary diastolic dysfunction.
2. Severe chronic lung disease with pulmonary hypertension.
3. Restrictive pericarditis.
4. Atrial fibrillation.
5. Diabetes mellitus, type 2.
6. Renal insufficiency.
7. Sleep apnea.
8. Status post aortic valve replacement.

DISCHARGE MEDICATIONS: The patient will continue with his regular home medications, Lotrisone b.i.d. to penis is advised.

DISPOSITION: Discharged home with followup appointment in one week.

SUMMARY: This is a 67 year old with a history of congestive heart failure with known restricted pericarditis, mild decreased LV function and diastolic dysfunction. He presented with increasing shortness of breath and weight gain. He basically wasn't able to breathe and had to get up out of bed and take his BIPAP machine off. He'd noticed significant increased weight gain of about 15 lbs and had had some more hypersomnolence during the day with marked dyspnea on exertion, according to the family.

PHYSICAL EXAM: On presentation, he was alert. He had his heart rate in the 70s and atrial fib. BP was 120/70, respiratory rate down to 20 after presentation of 34. His O2 sat was 96%. HEENT - Unremarkable. He had evidence of a mild balanitis which we thought was candidal in origin. He had no audible bruit. He had evidence of his valve click with no diastolic component. He had 1+ pitting edema bilaterally.

LABORATORY: Chest x-ray showed a large pleural effusion. White count was normal. Hemoglobin was 97, platelet count normal. BUN was 32 with a creatinine of 1.9. Potassium was low at 3.0 with a sodium of 130. Troponin was normal and Digoxin level was therapeutic at 0.96.

HOSPITAL COURSE: He was admitted to the hospital. We discontinued his Glucophage because of his elevated BUN and he was placed on other oral hyperglycemic agents at that time. We diuresed him as aggressively as we could. He was seen by Urology services who agreed with our diagnosis. A CT scan of his chest was performed which showed evidence of a pleural effusion, but no other major abnormalities. His clinical course was one of gradual improvement. Shortness of breath improved. Weight came down. It is felt that his primary problem is most likely his diastolic

***** DISCHARGE SUMMARY *****

RECEIVED MAR 10 2004

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/19/04

DISCHARGE DATE: 01/22/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

dysfunction with his restrictive pericarditis. Should he continue to worsen, or have a recurrence of this process, the we feel that he should be re-evaluated at UVA with a possible repeat cath to determine if there is a worsening of his restrictive component. He is discharged home in improved condition to followup on a outpatient basis.

Lynn N. Smith, M.D.

D: 03/06/04 0828

T: 03/08/04 0841

VGC

PMT, INC. #13216

***** DISCHARGE SUMMARY *****

RECEIVED MAR 10 2004

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028
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GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D-318

UNIT #: D000038770

ADMISSION DATE: 01/26/04

ATTENDING PHYSICIAN: Dr. John W Galbreath

CHIEF COMPLAINT: "My fluid"

HISTORY OF PRESENT ILLNESS: This is a 67 year old white male, patient of Dr. Lynn Smith, just discharged from the hospital on January 22nd. Since that time he has had increasing shortness of breath and dyspnea on exertion. He started wearing his oxygen full time and even then could not gain any relief. He was seen by the Home Health Nurse who told him today that he "definitely should go to the hospital". Patient was evaluated in the Emergency Department where he was found to have a moderate right sided pleural effusion. This was seen on previous film according to reading his old records. We do not have old x-rays at this point and time to see whether or not it has grown. At any rate the patient is having increasing symptoms and will be admitted to the hospital at this time for further evaluation and management of probable congestive heart failure. Patient does claim to have gained 14 pounds since his discharge five days ago.

PAST MEDICAL HISTORY: Significant for longstanding left ventricular systolic dysfunction with ejection fraction estimated at 15% on MUGA scan last summer, chronic atrial fibrillation, cor pulmonale, prosthetic aortic valve due to rheumatic heart disease, restrictive pericarditis, severe sleep apnea, type 2 diabetes mellitus, COPD, hypothyroidism. he is having problems with balanitis and was started on Lotrisone ointment the last time. Also previous toxic shock. He does have a pacemaker.

ALLERGIES: None.

MEDICATIONS on presentation included Reglan, 10 mgs tid, Nexium, 20 mgs a day, Demadex, 100 mgs bid, potassium, 80 mEq a day, Metaglip, 5/500 bid, Neurontin, 400 mgs qid, Digitek, 0.125 mgs a day, Synthroid, 125 mgs a day, Flomax, 0.4 bid, Proscar, 5 mgs a day, Coumadin, 8 mgs alternating with 7 mgs each night, Allopurinol, 300 mgs a day and Zaroxolyn, 5 mgs a day.

ALLERGIES: None.

SOCIAL HISTORY: Patient is accompanied today by his wife. Ongoing cigarette smoking history. previous alcohol but none currently.

REVIEW OF SYSTEMS:

HEENT: No headache, nosebleed or visual problems.

Cardiac: No chest pain, pressure or palpitations. Has been sleeping sitting up lately. Denies PND. Has noticed increasing lower extremity edema.

Pulmonary: Positive for shortness of breath even at rest today. He does have occasional cough with "thick brown sputum", no hemoptysis. He is more comfortable

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RECEIVED JAN 30 2004

029
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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

wearing oxygen at this point.

GI: He admits to increasing abdominal girth. Appetite has been fair. Has occasional reflux problems.

GU: He feels like his balanitis is coming along pretty well.

Bones and joints; No acute pain.

Neurologic: He does have problems with his neuropathy, no seizure, stroke or loss of consciousness. He felt a little lightheaded earlier today.

Constitutional negative for fever, chills or night sweats. Positive for weight gain to the tune of about 14 pounds as described above.

PHYSICAL EXAM: An elderly male appearing in no acute distress. Temperature is 98.4, heart rate was 127 on presentation, now closer to 100, respiratory rate on presentation, now closer to 20, blood pressure 112/66, O2 saturation was 87% on room air. On 3 liters O2 saturation is 97%.

HEENT: The oral mucosa is a little dry. Sclerae are anicteric. Neck is thick, 1 or 2 cms JVD sitting up, no bruits auscultated, no lymphadenopathy appreciated.

Chest Decreased breath sounds to the right with dullness to percussion. A few faint crackles at the left base as well.

Heart: Mechanical valve sound without murmur and irregularly irregular with controlled rate.

Abdomen is obese and distended with active bowel sounds, fairly soft. He is sitting up and I cannot appreciate organomegaly. There is some degree of HJR.

Genital and rectal were deferred.

The extremities revealing 2+ nonpitting edema, some stasis dermatitis. pulses diminished in the feet, preserved in the wrists.

Neurologic is grossly normal.

Psychiatric is grossly normal.

Chest x-ray shows a moderately sized right pleural effusion. INR was 3.2, PTT 35.4, white count is 8.9, hemoglobin 9.8, hematocrit 31.5, platelets 294. Blood gas on two liters showed a pH 7.47, PCO2 of 51, PO2 of 71, bicarb of 37, saturation 95%. B natriuretic peptide is 116, sodium 131, potassium 3.1, chloride 87, BUN 33, creatinine 1.8, albumin 3.5, calcium 7.5, total bilirubin 0.74, AST 18, ALT 26, alk phos 103, magnesium 1.6. An EKG showing atrial fibrillation.

ASSESSMENT:

1. Middle-aged male with recurrent congestive heart failure, presenting with increased shortness of breath, right pleural effusion, reported 14 lbs weight gain over the past seven days.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN:

1. Admit to medical floor.
2. IV Demadex.
3. Sliding scale insulin.
4. Other home medicines as prior presentation.
5. Transfer to Dr. Smith's service in the morning.
6. Resume Bi-Pap.
7. Oxygen, 3 liters.

John W. Galbreath, M.D.

D: 01/26/04 1823
T: 01/26/04 1836
VMN

PMT, Inc., Job #03087

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GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.200

UNIT #: D000038770

ADMISSION DATE: 01/19/04

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

PATIENT PROFILE: This is a 67 year old with a history of congestive heart failure with known restrictive pericarditis and decreased LV function. He has a history of COPD, diabetes, history of toxic shock, mild renal insufficiency.

CHIEF COMPLAINT: Shortness of breath.

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater has been doing very well but on Wednesday evening he woke up and he basically couldn't breathe. He said he was very short of breath, had to get up out of bed, take his BIPAP machine off. He didn't have any chest pain with this but it lasted for a while. He was finally able to lie on his side and go back to sleep but he has had increasing weight gain of about 15 pounds over the last week. He has been sleeping more during the day. He has been sleeping more at night, a little more hypersomnolent according to the family. He really denies any chest pain. He says he hasn't felt that much worse except for the fact that he has had the shortness of breath and the dyspnea on exertion. He has also noted some swelling in the penile region and has had a history of a balanitis and a phimosis in the past.

PAST MEDICAL HISTORY: He is status post a prosthetic aortic valve due to rheumatic heart disease. He has had a restricted pericarditis. He has known severe sleep apnea, type 2 diabetes, chronic lung disease, hypothyroidism, BPH. He has also had two episodes of toxic shock, the last one resulted actually in renal failure transiently.

PAST SURGICAL HISTORY: He has had a mechanical aortic valve implanted, cholecystectomy, bilateral carpal syndrome surgery and a pericardial stripping. Pacemaker placed.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS: Reglan, Demadex, Nexium, Digitek, Synthroid, Flomax, Proscar, Coumadin, Synthroid, Allopurinol, Zaroxolyn, Metaglip and potassium.

SOCIAL HISTORY: He is married, lives at home with his wife. He is a retired coal miner. He has a longstanding history of cigarettes. He was also a fairly heavy drinker in the past but he has not had any of these for a number of years.

FAMILY HISTORY: Mother died of complications of diabetes. Father died with a CVA.

REVIEW OF SYSTEMS: He says other than this he has been doing well. Appetite has been good. He has had no visual changes, difficulty in hearing. No difficulty in swallowing. No chest pains, palpitations. He has had the PND with increasing edema.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

and abdominal girth. He has had some mild urinary symptoms. He has had the swelling on the penis. No polyuria or polydypsia or musculoskeletal complaints.

PHYSICAL EXAM: He is alert and oriented at this time. He says he is actually feeling pretty good. His heart rate is in the 70s, in atrial fib. Blood pressure is 120/70, respiratory rate is down to 20, O2 sat is 96% on oxygen. His skin shows no suspicious lesions other than the penis and he does have a very red and inflamed balanitis, possibly candidal in origin. No other rashes are noted. Pupils are equal and reactive. Sclera and conjunctiva are unremarkable except for some mild pallor. Good carotid upstrokes. I do not hear any audible bruits. Thyroid is not enlarged. He has decreased breath sounds at his bases but otherwise are clear. Mild decreased dullness at the right base. Cardiac shows an irregular rate and rhythm with his valvular click. I do not hear any other diastolic components. Abdomen is obese. Bowel sounds are active. I cannot feel any palpable fluid waves. Rectal is not performed. Extremities show 1+ pitting edema with chronic stasis changes. No evidence of rash or cellulitis at this time. Pulses are diminished. Neurological: He is alert and oriented. No confusion or disorientation.

LABORATORY: His chest x-ray shows a fairly large right pleural effusion. White count is normal with a hemoglobin of 97, normal platelet count. BUN 32 with a creatinine of 1.9. Potassium is low at 3.0 with a sodium of 130. Troponin is normal. Dig level is therapeutic .96. His INR is also therapeutic at 3.8. EKG shows atrial fibrillation at this time with no other acute changes.

IMPRESSION:

1. Congestive heart failure with new right pleural effusion.
2. Chronic atrial fibrillation.
3. Status post valve replacement with cor pulmonale.
4. Restricted pericarditis
5. Diabetes mellitus.
6. Probable phimosis.
7. History of toxic shock.
8. Renal insufficiency.

PLAN: He is admitted at this time. We will, actually because of his elevated

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GREENBRIER VALLEY MEDICAL CENTER
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

creatinine, discontinue his Glucophage. He will be treated with an oral hypoglycemic, monitor his sugars closely. Will arrange for urology to see him, put him on IV antibiotics at this time. Continue with aggressive diuresis. Replace his potassium.

Lynn N. Smith, M. D.

D: 01/19/04 1702
T: 01/19/04 1756
KAC

PMT01356

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**VALLEY MEDICAL ASSOCIATES, INC.**

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

HC 70, Box 16 (Rt. 92)
White Sulphur Springs, WV 24986
(304) 536-1014

HOLTER MONITOR REPORT
Lynn N. Smith, M.D.

PATIENT : FITZWATER, Jackie

DATE : 11-13-03

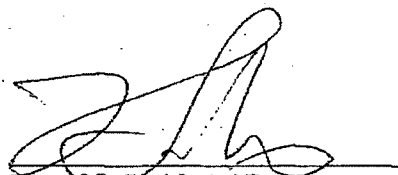
REFERRING PHYSICIAN : Dr. Lynn Smith

INDICATIONS FOR PROCEDURE : Skipped beats.

INTERPRETATION : There is 23 hours and 46 minutes of tracing available. The patient's underlying rhythm appears to be multifocal atrial rhythms with episodes consistent with atrial fibrillation. There are also episodes that would be suggestive of atrial flutter with a heart rate of 150. This is sustained for a great portion of this test.

IMPRESSION :

1. PROBABLE EPISODIC ATRIAL FIBRILLATION WITH EPISODES OF ATRIAL FLUTTER WITH RAPID VENTRICULAR RESPONSE – Clinical correlation is advised.



Lynn N. Smith, M.D.

T: 12-05-03/mek

**Heart Center-UVA Health System
Echocardiogram Report****Patient Name:** Fitzwater, Jackie Lee**MR Number:** 1204422**Account #:** 3058976014**Procedure Date:** 07/02/03**IP/OP Status:** Outpatient**Patient Location:****Referring MD:** Elizabeth Le, M.D.**Sonographer:** Larry Berry, R.D.C.S.**Tape:** LAB 237 / 01:10:26**Symptoms:** SOB, LE edema.**Conditions:** post 25mm ST Judes AVR in 1998, right heart failure, s/p pericardiectomy.**Evaluate for:** LV Function, Valvular Heart Disease**Procedure:** Transthoracic echocardiogram with M-Mode, 2D, Doppler, and Color Doppler examination.**BP:** 0/0 mm/Hg**HR:** bpm**Height:** 69 in**DOB:** 04/25/1936**Sex:** Male**Weight:** 249 lbs**Measurements:**Dimensions: (cm)Normal Value:Dimensions: (cm)Normal Value:**2D Findings:****Study Quality:** difficult**LV Function:** Normal left ventricular function.**LV Size/Thickness:** Mild left ventricular hypertrophy.**Right Ventricle:** Right ventricular enlargement with decreased RV function.**Left Atrium:** Normal left atrium.**Right Atrium:** Moderate right atrial enlargement.**Aorta:** Normal aorta.**IVC:** Inferior vena cava enlarged. Inferior vena cava lacked normal respiratory variation.**Mitral Valve:** Mitral valve leaflets mildly thickened.**Aortic Valve:** Mechanical Aortic Valve replacement noted.**Tricuspid Valve:** Tricuspid valve was not well seen.**Pulmonic Valve:** Pulmonic valve was not well seen.**Pericardium:** No pericardial effusion.**Masses/Thrombi:** No masses.**Doppler Findings:**

No mitral regurgitation.

Minimal aortic regurgitation. Peak transaortic valve gradient equals 43 mm/Hg, mean gradient equals 24 mm/Hg.

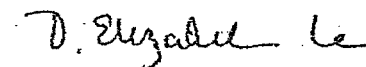
Mild tricuspid regurgitation.

No pulmonic regurgitation.

Conclusions:

The study was difficult due to body size/body habitus.

Right ventricular enlargement with decreased RV function. Normal left ventricular function. Mild left ventricular hypertrophy. Inferior vena cava enlarged. Inferior vena cava lacked normal respiratory variation. Transaortic valvular gradients are within normal limits for 25 mm St. Judes Valve in aortic position.



07/02/03

14:14:02

Interpreting Physician
Elizabeth Le, M.D.

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 06/17/03 DISCHARGE DATE: 06/30/03
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure.
2. Restrictive pericarditis with cor pulmonale.
3. Renal insufficiency.
4. Chronic obstructive pulmonary disease.
5. Type 2 diabetes.
6. Sleep apnea.
7. Peripheral neuropathy.
8. Status post a valve replacement.
9. Gout.

DISCHARGE MEDICATIONS: O2 at 2 liters with BIPAP, Synthroid 0.200 mg per day, Demadex 100 mg p.o. b.i.d., Aldactone 50 mg p.o. b.i.d., Zoloft 50 mg q. h.s., Coumadin 6 mg alternating 7 mg per day, Allopurinol 300 mg a day, Lanoxin 0.125 mg per day, Doxycycline 100 mg q. day times 6 days, Neurontin 400 mg q.i.d., Prilosec 20 mg a day, Metaglip one p.o. b.i.d., Flomax 0.1 mg per day. The patient is not to be on any potassium and no Zaroxolyn at this time. He is to take iron supplementation one p.o. b.i.d.

HISTORY: This is a 67 year old gentleman who presents with increasing weight gain and shortness of breath. He was doing well until about a week ago when he suddenly began increasing weight and gained 15 lbs in the last week. Marked increasing peripheral edema, shortness of breath, and weeping from his lower legs. He has a history of congestive heart failure, predominantly right sided, due to a restrictive pericarditis. Also, he has started some left-sided failure as of recent. He is status post valve replacement. No history of any chest pain or sputum production.

PHYSICAL EXAM: His weight was up to 264. Blood pressure was 124/60 with a pulse of 88. HEENT - Unremarkable. He had a valve click with no new murmurs. LUNGS - Fields show some minimal rales at his bases. ABDOMEN - He is morbidly obese with a positive hepatojugular reflux. He had questionable acidic fluid present. EXTREMITIES - He had 3-4+ pitting edema with some an open area with some mild weeping on the left lower leg.

HOSPITAL COURSE: The patient was admitted and was started on IV diuresis. He continued with his regular medications. His weight began to come down. His potassium improved on Aldactone. This was added to his therapy in an attempt to decreased his potassium loss and to use a combination for his diuresis. His eight dropped about 14 lbs without difficulty. The patient was able to ambulate well and felt much better. He was started on some Doxycycline for some scalp lesions which

***** DISCHARGE SUMMARY *****

RECEIVED JUN 29 2003

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037
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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 06/17/03 DISCHARGE DATE: 06/30/03
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

were sort of crusty and had been treated in the past with antibiotics. Overall, he felt much better. His weight was down. Ambulation and appetite were good. Long term prognosis at this time is quite guarded. He will be discharged home in improved condition to followup on an outpatient basis.

Lynn N. Smith, M.D.

D: 07/26/03 0930
T: 07/28/03 1046
VGC

PMT, INC. #19208

***** DISCHARGE SUMMARY *****

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038
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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 05/29/03

DISCHARGE DATE: 06/13/03

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure secondary to decreased LV function and restrictive pericarditis.
2. Iron deficiency anemia secondary to chronic blood loss.
3. Gastritis.
4. Chronic obstructive pulmonary disease.
5. Diabetes mellitus type 2 on oral agents.
6. Status post aortic valve replacement.
7. Chronic obstructive pulmonary disease.
8. History of diverticulosis.

DISCHARGE MEDICATIONS: The patient will resume his regular home meds at this time including his Coumadin. He will also be placed on Zaroxolyn 2.5 mg per day in combination with his Demadex. The remainder of his home meds will remain the same at this time.

DISPOSITION: He was discharged home with followup appointment in approximately two weeks.

SUMMARY: This is a 67 year old gentleman with known restrictive pericarditis, history of congestive failure and chronic obstructive pulmonary disease. He has been having worsening problems with cor pulmonale and congestive failure over this time frame. He'd had marked weight reduction initially, but in the last two to three weeks gained 15 to 16 lbs and was now having increasing shortness of breath, weakness, dyspnea and frank orthopnea. His multi problems including restrictive valvular heart disease. His valve replaced due to rheumatic heart disease. He has had two episodes of Strep infections with toxic shock syndrome and renal failure within the last year or two.

PHYSICAL EXAM: On exam, he was alert and in moderate respiratory distress. BP was 118/80 with a pulse of 82, respirations 24. He had some chronic changes on his skin with some mild ecchymotic areas, a couple of small vesicular lesions on the side of the leg. HEENT - Otherwise unremarkable. He had bilateral rales with a valve click. No new murmurs. He had flank edema and significant 2-3+ pitting edema. RECTAL - The prostate was mildly enlarged, but no stool was present for testing. EXTREMITIES - Unremarkable except for his edema and did not show any evidence of any active cellulitis.

HOSPITAL COURSE: He was admitted and was started on IV diuretics with Lasix and oral Zaroxolyn. Daily weights were obtained. He actually began to diurese fairly well and was losing quite a bit of weight. His hemoglobin was noted to be down to 8.2

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 05/29/03

DISCHARGE DATE: 06/13/03

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

with microcytic indices. He had been gradually decreasing for some time and stools had been hemepositive. His INR had been in the therapeutic range at 3.1. It was felt that further evaluation of his iron deficiency anemia was necessary. We subsequently stopped his Coumadin and put him on IV Heparin. He was seen by Dr. Jones and both a colonoscopy and EGD were performed. It showed evidence of some mild to moderate gastritis, but no other evidence of any suspicious lesions. He was put on iron therapy hopefully to maintain an improvement in his overall iron deficient state. He was started back on his Coumadin and gradually got back into a therapeutic response with his INR up into the 3.1 range. He underwent a MUGA scan which showed an EF of about 16%. This was a marked change in this gentleman from previously. As before, his failure though has always been right sided related to his restrictive pericarditis. Now, we were having evidence of biventricular failure associated with a marked reduction in LV function based upon his MUGA scan. We talked to his Cardiologist at the University of Virginia. It was felt that further investigation was indicated. Our plans at this time are once he is discharged to arrange for him to be seen on an outpatient basis at UVA. He will possibly undergo another cardiac cath for re-evaluation. At this time, he is discharged home in improved condition and will be followed closely at home with Home Health Services and will followup in the office as indicated.

Lynn N. Smith, M.D.

D: 06/28/03 0934

T: 06/30/03 0859

VGC

PMT, INC. #12700

***** DISCHARGE SUMMARY *****

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040
App.000304

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 05/29/03 DISCHARGE DATE: 06/13/03
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure secondary to decreased LV function and restrictive pericarditis.
2. Iron deficiency anemia secondary to chronic blood loss.
3. Gastritis.
4. Chronic obstructive pulmonary disease.
5. Diabetes mellitus type 2 on oral agents.
6. Status post aortic valve replacement.
7. Chronic obstructive pulmonary disease.
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DISCHARGE MEDICATIONS: The patient will resume his regular home meds at this time including his Coumadin. He will also be placed on Zaroxolyn 2.5 mg per day in combination with his Demadex. The remainder of his home meds will remain the same at this time.

DISPOSITION: He was discharged home with followup appointment in approximately two weeks.

SUMMARY: This is a 67 year old gentleman with known restrictive pericarditis, history of congestive failure and chronic obstructive pulmonary disease. He has been having worsening problems with cor pulmonale and congestive failure over this time frame. He'd had marked weight reduction initially, but in the last two to three weeks gained 15 to 16 lbs and was now having increasing shortness of breath, weakness, dyspnea and frank orthopnea. His multi problems including restrictive valvular heart disease. His valve replaced due to rheumatic heart disease. He has had two episodes of Strep infections with toxic shock syndrome and renal failure within the last year or two.

PHYSICAL EXAM: On exam, he was alert and in moderate respiratory distress. BP was 118/80 with a pulse of 82, respirations 24. He had some chronic changes on his skin with some mild ecchymotic areas, a couple of small vesicular lesions on the side of the leg. HEENT - Otherwise unremarkable. He had bilateral rales with a valve click. No new murmurs. He had flank edema and significant 2-3+ pitting edema. RECTAL - The prostate was mildly enlarged, but no stool was present for testing. EXTREMITIES - Unremarkable except for his edema and did not show any evidence of any active cellulitis.

HOSPITAL COURSE: He was admitted and was started on IV diuretics with Lasix and oral Zaroxolyn. Daily weights were obtained. He actually began to diurese fairly well and was losing quite a bit of weight. His hemoglobin was noted to be down to 8.2

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 05/29/03 DISCHARGE DATE: 06/13/03
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

with microcytic indices. He had been gradually decreasing for some time and stools had been hemepositive. His INR had been in the therapeutic range at 3.1. It was felt that further evaluation of his iron deficiency anemia was necessary. We subsequently stopped his Coumadin and put him on IV Heparin. He was seen by Dr. Jones and both a colonoscopy and EGD were performed. It showed evidence of some mild to moderate gastritis, but no other evidence of any suspicious lesions. He was put on iron therapy hopefully to maintain an improvement in his overall iron deficient state. He was started back on his Coumadin and gradually got back into a therapeutic response with his INR up into the 3.1 range. He underwent a MUGA scan which showed an EF of about 16%. This was a marked change in this gentleman from previously. As before, his failure though has always been right sided related to his restrictive pericarditis. Now, we were having evidence of biventricular failure associated with a marked reduction in LV function based upon his MUGA scan. We talked to his Cardiologist at the University of Virginia. It was felt that further investigation was indicated. Our plans at this time are once he is discharged to arrange for him to be seen on an outpatient basis at UVA. He will possibly undergo another cardiac cath for re-evaluation. At this time, he is discharged home in improved condition and will be followed closely at home with Home Health Services and will followup in the office as indicated.

Lynn N. Smith, M.D.

D: 06/28/03 0934
T: 06/30/03 0859
VGC

PMT, INC. #12700

***** DISCHARGE SUMMARY *****

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042
App.000306

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 05/14/03

DISCHARGE DATE: 05/18/03

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure.
2. Restrictive pericarditis with cor pulmonale.
3. Renal insufficiency.
4. Chronic obstructive pulmonary disease.
5. Type 2 diabetes.
6. Sleep apnea.
7. Peripheral neuropathy.
8. Status post a valve replacement.
9. Gout.

DISCHARGE MEDICATIONS: O2 at 2 liters with BIPAP, Synthroid 0.200 mg per day, Demadex 100 mg p.o. b.i.d., Aldactone 50 mg p.o. b.i.d., Zolof 50 mg q. h.s., Coumadin 6 mg alternating 7 mg per day, Allopurinol 300 mg a day, Lanoxin 0.125 mg per day, Doxycycline 100 mg q. day times 6 days, Neurontin 400 mg q.i.d., Prilosec 20 mg a day, Metaglip one p.o. b.i.d., Flomax 0.1 mg per day. The patient is not to be on any potassium and no Zaroxolyn at this time. He is to take iron supplementation one p.o. b.i.d.

HISTORY: This is a 67 year old gentleman who presents with increasing weight gain and shortness of breath. He was doing well until about a week ago when he suddenly began increasing weight and gained 15 lbs in the last week. Marked increasing peripheral edema, shortness of breath, and weeping from his lower legs. He has a history of congestive heart failure, predominantly right sided, due to a restrictive pericarditis. Also, he has started some left-sided failure as of recent. He is status post valve replacement. No history of any chest pain or sputum production.

PHYSICAL EXAM: His weight was up to 264. Blood pressure was 124/60 with a pulse of 88. HEENT - Unremarkable. He had a valve click with no new murmurs. LUNGS - Fields show some minimal rales at his bases. ABDOMEN - He is morbidly obese with a positive hepatojugular reflux. He had questionable acidic fluid present. EXTREMITIES - He had 3-4+ pitting edema with some an open area with some mild weeping on the left lower leg.

HOSPITAL COURSE: The patient was admitted and was started on IV diuresis. He continued with his regular medications. His weight began to come down. His potassium improved on Aldactone. This was added to his therapy in an attempt to decreased his potassium loss and to use a combination for his diuresis. His eight dropped about 14 lbs without difficulty. The patient was able to ambulate well and felt much better. He was started on some Doxycycline for some scalp lesions which

***** DISCHARGE SUMMARY *****

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043
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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 05/14/03

DISCHARGE DATE: 05/18/03

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

were sort of crusty and had been treated in the past with antibiotics. Overall, he felt much better. His weight was down. Ambulation and appetite were good. Long term prognosis at this time is quite guarded. He will be discharged home in improved condition to followup on an outpatient basis.

Lynn N. Smith, M.D.

D: 07/26/03 0930

T: 07/28/03 1046

VGC

PMT, INC. #19208

Corrected 8/15/03

***** DISCHARGE SUMMARY *****

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044
App.000308

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
ROOM #: D.302
ADMISSION DATE: 05/14/03
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DOB: 04/25/36
UNIT #: D000036770

PATIENT PROFILE: 67 year old with history of diabetes, congestive heart failure, cor pulmonale with restrictive pericarditis and COPD.

CHIEF COMPLAINT: Shortness of breath and weight gain.

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater was doing well until about a week ago and all of a sudden this gentleman began having significant increase in weight. He has gained 15 pounds in the last weeks, was noted to have some marked increasing peripheral edema and he was having weeping from his lower legs, frank PND, orthopnea and increasing shortness of breath. He has a history of heart failure both and left sided, predominantly related to a restrictive pericarditis problems. He is status post valve replacement which was a precipitating factor. He has had no chest pains, no cough or real sputum production during this time frame.

PAST MEDICAL HISTORY: He has diabetes, type 2, hypothyroidism, severe sleep apnea. History of restrictive pericarditis. He is status post aortic valve replacement due to rheumatic heart disease. He has also had a problem with recurrent cellulitis, has had strep infections on two occasions, one of which produced toxic shock syndrome and renal failure.

PAST SURGICAL HISTORY: He has had bilateral carpal tunnel syndrome. He has had a cholecystectomy, pericardial stripping. He has also had a mechanical aortic valve placed.

SOCIAL HISTORY: He is married, lives at home with his wife who takes care of him. He is a retired coal miner. He has a history of cigarettes in the past but he says he has not really smoked now for probably at least a year. No significant alcohol.

FAMILY HISTORY: His mother died as complications of diabetes. His father died with a stroke. There is no history of any other malignancies or premature heart disease.

REVIEW OF SYSTEMS: His appetite has been good up until recently. The weight is obviously up 15 pounds in the last week. HEENT: He does have some difficulty in hearing. He wears glasses. No difficulty in swallowing. Chest: He has had a minimal cough with no sputum production nor hemoptysis. Cardiac: No palpitations but marked increase in PND and orthopnea. GU: He has no real prostatism symptoms, has been voiding well. GI: No nausea, vomiting, diarrhea, hematochezia or melena. Musculoskeletal exam: He always has some sort of chronic pain. He hurts a little bit in his legs and back but overall does quite well. Neurologically: He has severe peripheral neuropathy with burning dyesthesias bilaterally. No focal motor weakness. No seizures or mental status change. Psyche: There is no history of any depression.

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045
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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PHYSICAL EXAM: His weight is up to 264.5, blood pressure 124/64 with a pulse of 88. He is alert and oriented. He is pretty dyspneic and wobbly when he gets up and stands. He is very short of breath and very weak. He has marked edema, 3-4+ in both legs all the way up into the flank region. Pupils are equal and reactive. No scleral icterus is noted. TMs are clear. Posterior pharynx is clear with plates. No carotid bruits. He has a positive hepatojugular reflux. Lung fields show rales at both bases. He has valve click with no diastolic component. No new murmurs or rubs. His abdomen is soft. He is markedly obese. He has probably some fluid present with ascites. Rectal is not performed. His extremities show the significant swelling with some weeping in the left lower leg. Not able to feel peripheral pulses at this time but there is no evidence of any cyanosis or clubbing. Neurologically he moves all extremities well. He is diffusely weak but does not have focal motor change.

IMPRESSION:

1. Congestive heart failure.
2. Restrictive pericarditis with cor pulmonale.
3. Renal insufficiency.
4. COPD.
5. Diabetes type 2.

PLAN: To admit him to try to facilitate diuresis at this time. We will reevaluate valve and cardiac integrity. Prognosis is guarded.

Lynn N. Smith, M. D.

D: 05/15/03 1510

T: 05/15/03 1629

KAC

PMT02844

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GREENBRIER VALLEY MEDICAL CENTER

P.O. BOX 497

RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.314

UNIT #: D000038770

ADMISSION DATE: 08/30/02

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

PATIENT PROFILE: This is a 66 year old with a history of chronic cor pulmonale with a restrictive pericarditis, history of diabetes, recurrent right sided failure and chronic lung.

CHIEF COMPLAINT: Shortness of breath and weight gain.

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater has been home for several months after a prolonged hospitalization after having toxic shock syndrome. He was treated at the University of Virginia where he also had heart failure and kidney failure at the time. After coming home he did quite well for a while, actually had been maintaining his baseline weight. Over about the last ten days he has had increasing shortness of breath and fatigue and has been on about 20 pounds in weight. He has frank orthopnea with dyspnea on exertion. He denies any chest pain nor has he had any fevers, chills or sweats.

PAST MEDICAL HISTORY: He has known pneumoconiosis, diabetes, hypothyroidism, severe sleep apnea. He has a history of restrictive pericarditis which was postoperative after an aortic valve replacement and rheumatic heart disease. He has a history of cellulitis in his legs and has the Strep cellulitis which produced a toxic shock syndrome.

PAST SURGICAL HISTORY: He has had a cholecystectomy, bilateral carpal tunnel syndrome. He has had pericardial stripping due to restrictive pericarditis and he has a mechanical aortic valve that was placed.

SOCIAL HISTORY: He is married, lives at home with his wife. He is a retired coalminer. He has a history of cigarettes in the past but has not smoked now for about six to seven months. No significant alcohol ingestion.

FAMILY HISTORY: Father died with a stroke. Mother had severe diabetes. No family history of any malignancies or history of coronary disease.

REVIEW OF SYSTEMS: Shows his appetite has been marginal, his weight is up 20 pounds in the last ten days.

HEENT: He has some mild difficulty hearing, wears glasses, no difficulty in swallowing.

Chest: He has had a little bit of cough which has been nonproductive. He has had no pleuritic pain or hemoptysis.

GI: No nausea, vomiting or diarrhea.

GU: He has some mild prostatism symptoms at times but voids fairly well. No hematuria.

Musculoskeletal: He has pain especially in his legs, hips and some in his hands.

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047
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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Endocrine: He has occasional polyuria. He has marked peripheral neuropathy symptoms bilaterally for which he has been on Neurontin.

Neuro/psyche: He evidently has just been very difficult to deal with according to the family. He has almost been hateful. He has no history of any confusion, disorientation or focal motor change at this time, no history of any seizure disorder.

PHYSICAL EXAM: He is alert, he is oriented, he is moderately dyspneic at rest. His respiratory rate is 22, his pulse is 114, blood pressure is 106/64. Patient appears alert and oriented but is obviously in moderate distress.

HEENT: Pupils are equal and reactive. He has no scleral icterus, mild pallor is noted. TM's are clear. He has dentures present with clear posterior pharynx. His neck has good upstroke. He has a positive hepatjugular reflux, no cervical adenopathy. Thyroid is not enlarged. His lungs show rales at both bases. Cardiac shows a regular rate and rhythm. He has an aortic valve click with no audible diastolic component. A systolic flow murmur is noted. No audible S3 or S4 is present.

His abdomen is obese, bowel sounds are active. He has no significant tenderness, organomegaly or bruits at this time. Stool is heme negative.

Extremities show 2 to 3+ pitting edema. He has violaceous changes in his lower extremities without a lot of erythema. A lot of this is stasis dermatitis type problems. He has markedly diminished pulses palpable at this time. No frank clubbing is noted.

Neurologically he is alert and oriented. Cranial nerves are unremarkable. Reflexes are symmetrical except absent in the lower extremities. He has no pathological reflexes at this time.

LABORATORY shows that his pro time is therapeutic at 3.25, his hemoglobin is down to 9.1 with normal indices, electrolytes are unremarkable with a BUN of 1.5, liver functions are normal.

IMPRESSION:

1. Worsening cor pulmonale with marked fluid retention.
2. Anemia, questionable etiology.
3. Valvular heart disease, status post prosthetic valve.
4. Restrictive pericarditis.
5. Pneumoconiosis.
6. Hypothyroidism on replacement.

PLAN: He is admitted, will have diuresis at this time, evaluation of anemia to determine if this has been secondary to blood loss or chronic disease. He will continue with his anticoagulation due to his prosthetic valve at this time. Monitor

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048

App.000312

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

closely for any infectious complications but there is no evidence of that at this time.

Lynn N. Smith, M.D.

D: 08/31/02 0654
T: 08/31/02 1219
VMN

PMT, Inc., Job #7980

RECEIVED SEP 05 2007

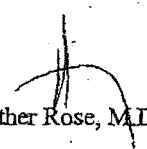
VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & ReportX-Ray No. 2958Date 10401Age 42536Referring Physician SmithExamination Desired CXRR Decub.Clinical Information ? fluid SOB pt weight 260 lbs**Radiology Report****JACKIE FITZWATER****CHEST - W/ DECUBITUS:****HISTORY:** Shortness of breath.

There is a moderate to large right pleural effusion which layers on the decubitus view. There has been a previous sternotomy. There appears to be cardiomegaly.

IMPRESSION: RIGHT EFFUSION.


Signed by Heather Rose, M.D.

T: 1-09-01
HR/mek

mc Jackie Fitzwater Age 65 Date 10/12/01
 complaint F/U -

Lynn N. Smith, M.D.
 Doris A. Ragsdale, M.D.

**FLU
VACCINE**

Date 10/12/01

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 262 1/2 BP 132/10 Pulse 92 Temp _____ Resp _____

Jackie L. Fitzwater

10/11/01

Lynn N. Smith, M.D.

S: Jackie continues to do well. His weight has stabilized. He has had a little bit of a URI complaint but he has overall been out painting and working, doing things that he has not done for quite a while. No chest pain; minimal dyspnea on exertion.

Past medical history is significant for his corpulmonale with restrictive pericarditis. He has COPD. He has a history of diabetes, morbid obesity and a history of CHF. He is s/p valve replacement. ROS shows appetite has been good. His peripheral edema has been down. He has had no real leg complaints as far as cramps or pains. No PND or orthopnea. He has had some mild dyspnea on exertion but much improved. He has actually improved his activity level.

EXAMINATION: Lungs are clear. RRR. His valve click is present with no new murmurs or gallops. He is still morbidly obese and I cannot feel anything different in the abdomen. He has trace to 1+ edema which is good for him. He still has the area on this left leg that was biopsied and was evidently negative but we do not have the pathology report.

IMPRESSION:

1. Restrictive pericarditis with corpulmonale, stable.
2. Hypothyroidism, improved.

PLAN: 1. We will recheck his protime, BMP. We will try to get the report on his leg as far as the lesion that was biopsied. 2. His TSH will also be monitored and dosage adjustment. 3. A flu shot is given today. 4. He will f/u for his routine visit.

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie L. Fitzwater**09/11/01****Lynn N. Smith, M.D.**

S: Jackie is back in for his f/u. He seems to continue to be doing well. He has put on a little more weight since going home but he says that he is much more active. He feels well. He has not been short of breath. He has had no palpitations. Overall he says that he is much improved.

His recent medical history has been that of an upper GI bleed due to a gastric ulcer. He has known hypothyroidism, restrictive pericarditis with corpulmonale s/p valve replacement. His last lab work shows that his hemoglobin had come up to 13. A1C level was 7.0. Potassium was up to 3.5 and all of his other parameters actually were good.

EXAMINATION: Weight 262 lbs. BP: 122/80 and under good control. No JVD. Thyroid is not palpably enlarged. Lungs are clear. Cardiac shows his valve click with no new murmurs or gallops. He has about 1+ edema which is good for him. He has had a biopsy on the left leg. We have removed stitches at this time. He was told that it was evidently not malignant but we do not have a definitive

Jackie Fitzwater**09/11/01****Lynn N. Smith, M.D.****Page 2**

diagnosis.

IMPRESSION:

1. S/P valve replacement.
2. Restrictive pericarditis with corpulmonale.
3. Hypothyroidism.
4. Recent GI bleed.

PLAN: 1. His protime is obtained at this time. We will also get his TSH level, continue with his current medical management and f/u in two months.

L. Smith, M.D./ssd/D: 09-11-01/T: 09-14-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie Fitzwater**08/29/01****Lynn N. Smith, M.D.**

S: Mr. Fitzwater is back in. He has actually been doing quite well. His weight has been under good control. He has felt very well. He has had much less shortness of breath. Much less peripheral edema. He had one episode where he had to take some of his Zaroxolyn but his weight is down to about 233 lbs. and has been extremely stable. He has had no further episodes of any bleeding to the best of his knowledge.

Past medical history is significant for valvular heart disease. He has had a recent GI bleed due to peptic ulcer disease. He has known restrictive pericarditis with a history of corpulmonale and marked hypothyroidism which is on replacement.

EXAMINATION: Lungs are clear. He has his valve click. No new murmurs. Thyroid is not palpably enlarged. He has trace peripheral edema which is excellent for this gentleman. He has some peripheral neuropathic symptoms still at this time with his legs.

IMPRESSION:

1. S/P valve replacement.
2. COPD.
3. Restrictive pericarditis.
4. History of anemia.
5. Hypothyroidism.

PLAN: 1. We are going to check him at this time for his BMP. 2. He is due for his A1C level. 3. It is too early for his protime and that will be checked in about two weeks. 4. He will continue with his current therapy at this time.

L. Smith, M.D./ssd/D: 08-29-01/T: 08-30-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

8/6/01258118/6496SupB12 injection given

Jackie L. Fitzwater

08/06/01

Lynn N. Smith, M.D.

S: Jackie has done pretty well since he has gone home. He has put on a few lbs in weight as is expected since we cut down his diuretics to every other day but his weight is still in the 250's which is good for him. He has had no real shortness of breath. Unfortunately he continues to smoke. He has very limited activity at this time. Peripheral edema has been under good control but he has not had any significant orthostatic symptoms or lightheadedness.

Past medical history is significant for known restrictive pericarditis, history of severe hypothyroidism, corpulmonale and pneumoconiosis. He is s/p aortic valve replacement. This gentleman was recently hospitalized with a severe anemia and was found to have a small gastric ulcer. He has been on therapy at this time with no major symptoms. No melanotic stools. No pain.

EXAMINATION: His BP is good at 118 systolic. He is not tachycardic. Lungs are clear. No JVD. He has trace peripheral edema. He actually looks quite good for him.

Jackie Fitzwater

08/06/01

Lynn N. Smith, M.D.

Page 2

IMPRESSION:

1. Right-sided failure with restrictive pericarditis, corpulmonale.
2. History of GI bleed, secondary to gastric ulcer.
3. Pneumoconiosis.
4. History of anemia.

PLAN: 1. We are going to recheck his H&H, protime, BMP at this time. His TSH will also be monitored. 2. He will continue with his current medical therapy, watch his weight closely and f/u in approximately 3 months.

L. Smith, M.D./ssd/D: 08-06-01/T: 08-08-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzgerald

DATE

WT

BP

PULSE

CC:

7/12/01

271

102/52

100

freeze
lesions

Jackie Fitzgerald

7/26

Need 7/12

Rx: - Acute Pulmonary Heart Dis.
- GI Hemorrhage
- Anemia

SEARCH



7/19/01 Per LNS Rx'n called to Dermind Drug
for Coumadin 1mg tid as directed X 30 c
5RF's, Demadex 100mg tid X 60 c 5RF's & K-Dur
20mg tid X 90 c 5RF's

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE 7/23/01 WT 247 BP 108/62 PULSE 92 CC: Hosp. P/O

128/70 P-88

98/68 P-88

92/58 P-92

Jackie L. Fitzwater

07/23/01

Lynn N. Smith, M.D.

S: Jackie comes in after a recent hospitalization. He had a GI bleed with a history of peptic ulcer disease. He had significant anemia and marked corpulmonale. Since going home, his weight is now down to 247 lbs which is probably the lowest he has been in some time but he having some orthostatic symptoms and some dizziness. No chest pain. Shortness of breath has been stable. No active bleeding. We transfused him with a hemoglobin of about 10. His TSH was down to 16 after we had him on replacement therapy. Overall I think he has done better. Unfortunately he has returned to smoking and is smoking several cigarettes a day.

Past medical history is significant for pneumoconiosis, corpulmonale with a restrictive pericarditis, s/p valve replacement, type II diabetes, recent GI bleed due to peptic ulcer. **ROS:** Appetite has been good. He has not been sleeping well at night but a lot of it has been because he has been up diuresing. No chest pains or palpitations. He has had some weakness where he just has not felt like doing much. Bowel habits have been regular with no bright red blood or melanotic stools.

EXAMINATION: BP: 108/60. Lungs are clear. He has his valve click which is unchanged. No periorbital puffiness. No real palpable peripheral edema at this time.

IMPRESSION:

1. Restrictive pericarditis with corpulmonale.
2. Pneumoconiosis.
3. Recent GI bleed.
4. Anemia.

PLAN: 1. We will check his H&H, orthostatic pressures. We will also get his protime and BMP. 2. I have eliminated his Zaroxolyn for now because his weight is down so far. We will watch and see if his weight continues to come up about 4-5 lbs and then we may reinstitute it at that time. 3. F/u in approximately one month.

L. Smith, M.D./ssd/D: 07-23-01/T: 07-31-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

2:00 July 17th **PHONE CALL**

FOR Nurse DATE 6/26 TIME 3:39 **P.M.**

M _____

OF Jackie Fitzwater

PHONE ☐ FAX ☐ MOBILE ☐ AREA CODE 438 NUMBER 6633 EXTENSION _____

MESSAGE Lesion per Dr. Coum...
Wants to know if
Appt. has been made
with Dr. Spielman??

SIGNED _____

FORM 4003

6/28/01
Appt. Dr. Spielman
July 17 @ 2:00

Jackie L. Fitzwater

06/14/01

Lynn N. Smith, M.D.

S: Jackie was in the ER about one week ago. He evidently got up to go out on the porch to let the cat out and had a syncopal episode and hit his nose. Workup with CT scans and all of his lab work was unremarkable although his BP was down some at that time. He had lost about 20 lbs in weight with our diuresis and he was orthostatic. His Zaroxolyn was cut back to an every other a day basis. He is still having dizziness when he gets up and moves, albeit it is improved. He did not have any chest pains or palpitations with the episode. He still has felt a little dizzy when he gets up and moves now but it has improved some. His weight is also up a few lbs. He has had a little bit of nausea recently. He says he has had some early satiety but he has been on some medicines from the ER including steroids, mucolytic agents and antibiotics which all may be a culprit here.

EXAMINATION: Lungs are clear. No wheezes or rales. No JVD. He has his aortic valve click with no diastolic component. PMI is not displaced. He has about trace to 1+ edema which is good for him. He has a skin lesion on his left lower leg and one on his right pinna of his ear - both of which I think need to be removed because of the risk of them being malignant. No palpable organomegaly. No tenderness. He is slightly orthostatic when he stands up as it does drop 20mm and he does get a little dizzy.

IMPRESSION:

1. Restrictive paracarditis.
2. Orthostatic hypotension.
3. Hypothyroidism - his last TSH was 45.
4. Nausea, believed secondary to medication.

PLAN: 1. We will cut him down to every 4th day on his Zaroxolyn and watch his weight closely. 2. He has already had his thyroid medicine adjusted at this time. Hopefully his stomach will improve when he finishes these medications. He is going to contact me at the first of the week to let me know if things are improving.

L. Smith, M.D./ssd/D: 06-14-01/T: 06-21-01

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 65 SEX: M
ACCT: D00098208363 LOC: D.309 B
EXAM DATE: 07/12/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000244230 CHEST AP/PA & 1 LATERAL

PA AND LATERAL CHEST

Comparison is made with AP chest radiograph performed on 6/9/01 and 1/8/01.

The heart size remains enlarged. The patient is status-post median sternotomy. In the interval there has been development of a small right pleural effusion. There is moderate bilateral interstitial edema. Right basilar atelectasis is present as well.

IMPRESSION:

1. FINDINGS CONSISTENT WITH CONGESTIVE HEART FAILURE AND INTERVAL DEVELOPMENT OF RIGHT PLEURAL EFFUSION. FOLLOWUP TO COMPLETE RESOLUTION IS RECOMMENDED

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT: 6641

** Electronically Signed by Jay Jones M.D. on 07/16/2001 at 1424 **
Reported and Signed by: Jay Jones M.D.

CC: Lynn Smith, M.D.

DICTATED DATE/TIME: 07/15/2001 (1036)

TECHNOLOGIST: Jim L Carson RT(R)

TRANSCRIBED DATE/TIME: 07/15/2001 (1209)

TRANSCRIPTIONIST: PMIWJC

PRINTED DATE/TIME: 07/16/2001 (1441) BATCH NO: 5697

PAGE 1

Lynn Smith, M.D.

RECEIVED JUL 17 2001

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 65 SEX: M
ACCT: D00098208363 LOC: D.309 B
EXAM DATE: 07/15/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000244512 CHEST AP/PA & 1 LATERAL

CHEST AP AND LATERAL

The heart size remains enlarged. Small right pleural effusion persists. Overall mild interstitial edema persists, this is slightly decreased in the interval. Right basilar atelectasis is improved.

IMPRESSION:

1. CARDIOMEGALY AND MILD BILATERAL INTERSTITIAL EDEMA
2. SMALL RIGHT PLEURAL EFFUSION PERSISTS. FOLLOWUP TO COMPLETE RESOLUTION IS RECOMMENDED

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT: 6641

** Electronically Signed by Jay Jones M.D. on 07/16/2001 at 1424 **
Reported and Signed by: Jay Jones M.D.

CC: Lynn Smith, M.D.

Dictated Date/Time: 07/15/2001 (1036)

Technologist: Joe R Sparks RT(R)

Transcribed Date/Time: 07/15/2001 (1211)

Transcriptionist: PMTWJC

Printed Date/Time: 07/16/2001 (1442) BATCH NO: 5697

PAGE 1

Lynn Smith, M.D.

RECEIVED JUL 17 2001

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 65 SEX: M
ACCT: D00098198338 LOC: D.327 B
EXAM DATE: 05/08/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000233284 CHEST AP/PA & 1 LATERAL

CHEST, TWO VIEWS

Chest compared to prior study of 1/01.

Continued right effusion though improved in appearance.

Cardiomegaly. Venous congestion.

**IMPRESSION: UNDERLYING CONGESTIVE FAILURE WITH RIGHT EFFUSION. FOLLOW
UNTIL COMPLETE RESOLUTION.**

If this report has been electronically signed, the radiologist whose
name appears on this report has reviewed the films and the report.

PMT2282

** Electronically Signed by David C Maki D.O. on 05/08/2001 at 1845 **
Reported and Signed by: David C Maki, D.O.

CC: Lynn Smith, M.D.

Dictated Date/Time: 05/08/2001 (1458)

Technologist: Gary L Mabry RT(R)

Transcribed Date/Time: 05/08/2001 (1524)

Transcriptionist: PMTKAC

Printed Date/Time: 05/08/2001 (1853) BATCH NO: 5452

PAGE 1

Lynn Smith, M.D.

RECEIVED MAY 10 2001

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

RECEIVED FEB 28 2001

X-Ray Requisition & Report

X-Ray No. 2958
Date 2/2/01
Age 42536
Referring Physician D. Mann
Examination Desired CDR

Fitzwater
Jack

Clinical Information *Cough*

Radiology Report

JACK FITZWATER

CHEST, TWO VIEWS:

Two views of the chest are compared to prior study of 3/10/00.

Gross cardiomegaly. Right pleural effusion continues. Status post thoracotomy. Interstitial prominence with some venous congestion. Perhaps this patient has some degree of underlying chronic failure. Overall, findings are similar when compared to the prior study.

Signed by *[Signature]* David C. Maki, D.O.

T: 2-27-01
DM/mek

W

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 64 SEX: M
ACCT: D00098179648 LOC: D.331 A
EXAM DATE: 01/08/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000213467 CHEST AP/PA & 1 LATERAL

CLINICAL HISTORY: EFFUSION

There has been a slight improvement in the patient's effusion. A small to moderate right pleural effusion is identified. There is right basilar subsegmental atelectasis. There has been a previous sternotomy. Underlying COPD is seen.

IMPRESSION: SLIGHT IMPROVEMENT IN THE RIGHT EFFUSION.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

**** Electronically Signed by Heather Rose M.D. on 01/08/2001 at 1121 ****
Reported and Signed by: Heather Rose M.D.

CC: Lynn Smith, M.D.

dictated DATE/TIME: 01/08/2001 (0839)
TECHNOLOGIST: Susan B Poague RT(R) (M) (CT)
TRANSCRIBED DATE/TIME: 01/08/2001 (0942)
TRANSCRIPTIONIST: PMTLMC

PRINTED DATE/TIME: 01/08/2001 (1131) BATCH NO: 4883

PAGE 1

Lynn Smith, M.D.

RECEIVED 09 2001

laboratory Corporation of America
Ambulatory Monitoring Services
Burlington, North Carolina

cat

Patient Name : Fitzwater, Jackie
Age : 64
Sex : Male
Patient No. : 320-587-0323-0
Recording Date : 11-14-2000
Recording Length : 23 hrs 24 mins

Analysis Date : 11/17/2000
Physician : Smith
Hospital : Dr. Lynn Smith
Analyzer : P700 V8.202
Recorder Number : 47810025

Analysis Summary :

Normal Beat Total : 125282
PAC : 98 - 0.078 % of total beats
SVTs : 5 longest 85 beats at 19:15
fastest 163 bpm at 19:15

Aberrant Total : 220 avg 9 /hr - 0.2 % of total
PVC : 171 avg 7 /hr - 0.1 % of total
Couplets : 0
Triplets : 0
Ventricular Run : 0
VTs : 0

Bradycardia : 120 longest 8 beats at 02:10
slowest 43 bpm at 02:40
Dropped beats : 74
Pauses : 0

Maximum Heart Rate : 128 bpm at 17:42 (1 min Avg)
Mean Heart Rate : 90 bpm (1 min Avg)
Minimum Heart Rate : 65 bpm at 21:51 (1 min Avg)
QRS Total : 126302
Paced beats : 0

There were no episodes of AF.

Comments :

REASON FOR HOLTER: Palpitations

MEDICATIONS: No Meds. listed

PR = .18 sec

QRS = .08 sec

QT = .34 sec at 95 BPM

PREDOMINANT RHYTHM: Sinus rhythm with Multifocal PVC's.

ST-SEGMENT / T-WAVE CHANGES: Inverted T Waves CH I

SIGNIFICANT VENTRICULAR ECTOPY: Multifocal PVC's.

SIGNIFICANT ATRIAL ECTOPY: PAC's noted. Episodes of SVT.

PATIENT SYMPTOMS: No diary was submitted.

FOR ADDITIONAL ASSISTANCE PLEASE CALL 1-800-289-4358

TECHNICIAN: Karen Mitchell-Samuel

Episode
At 7:30 / 7:45
HR - 130 - 150 -

Signed

Laboratory Corporation of America
Ambulatory Monitoring Services
 Burlington, North Carolina

Patient Name : Fitzwater, Jackie
 Age : 64
 Sex : Male
 Patient No. : 320-587-0323-0
 Recording Date : 11-14-2000
 Recording Length : 23 hrs 24 mins

Analysis Date : 11/17/2000
 Physician : Smith
 Hospital : Dr. Lynn Smith
 Analyzer : P700 V8.202
 Recorder Number : 47810025

Analysis Summary :

Normal Beat Total : 125282
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ST-SEGMENT / T-WAVE CHANGES: Inverted T Waves CH I

SIGNIFICANT VENTRICULAR ECTOPY: Multifocal PVC's.

SIGNIFICANT ATRIAL ECTOPY: PAC's noted. Episodes of SVT.

PATIENT SYMPTOMS: No diary was submitted.

FOR ADDITIONAL ASSISTANCE PLEASE CALL 1-800-289-4358

TECHNICIAN: Karen Mitchell-Samuel

Laboratory Corporation of America
Ambulatory Monitoring Services
 Burlington, North Carolina

Patient Name : Lawson, Ora May
 Age : 48
 Sex : Female
 Patient No. : 320-587-0322-0

Analysis Date : 11/17/2000
 Physician : Thurman
 Hospital : Dr. Lynn Smith
 Analyzer : P700 V8.202

HR: 092

Name: KIE FITZWATER

ID :

Date: 12/28/99 Time: 12:57

Age: 63 Sex: MALE

Hgt: IN Vgt: LBS

Med1:

Med2:

Cell:

Cell2:

Cmnt:

NSR
PAELsVan Speake Tower
[Signature]

065

APR 09 2010

JetFax M910

123456

10/25/99 2:27PM; JetFax #419; Page 2/4

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
DISCHARGE SUMMARY

Name: FITZWATER, JACKY
Med Rec: 1204422
Admission: 10/14/99
Discharge: 10/21/99

ATTENDING PHYSICIAN: LAWRENCE W. GIMPLE, M.D.
REFERRING PHYSICIAN:

HISTORY: This is a 63-year-old white male with a history of diabetes mellitus, hypertension and aortic valve replacement secondary to a bicuspid aortic valve, who was transferred from Greenbriar Valley Medical Center for cardiac catheterization.

The patient was admitted to Greenbriar Hospital on October 11, 1999, with a several month history of increasing shortness of breath, a recurrent right pleural effusion and increasing right lower extremity edema. The patient had a right thoracentesis which reportedly came back as a transudate. The chest x-ray was consistent with congestive heart failure, by report. An echocardiogram, done at Greenbriar Hospital, revealed left ventricular hypertrophy with normal ejection fraction, no evidence of pulmonary hypertension and a normally functioning aortic prosthetic valve. The patient initially had symptomatic improvement after his right thoracentesis; however, he again developed recurrent shortness of breath. The patient was, thus, transferred to the University of Virginia for further evaluation and cardiac catheterization.

PAST MEDICAL HISTORY: 1. Aortic valve replacement, done in December 1998 with a St. Jude valve. 2. History of diabetes mellitus. 3. Hypertension. 4. COPD. 5. Obstructive sleep apnea. 6. Hypothyroidism. 7. Status post cholecystectomy. 8. Status post appendectomy. 9. Paroxysmal atrial fibrillation.

ALLERGIES: No known drug allergies.

ADMISSION MEDICATIONS: 1. Lasix 40 mg p.o. b.i.d. 2. Prevacid 15 mg p.o. q.d. 3. Synthroid 200 mcg p.o. q.d. 4. Metolazone 2.5 mg p.o. q.d. 5. Paxil 20 mg p.o. q.d. 6. Potassium 20 mEq p.o. t.i.d. 7. Propafenone 150 mg p.o. b.i.d. 8. Coumadin 6 mg p.o. q.h.s. 9. Tylenol on a p.r.n. basis. 10. Benadryl on a p.r.n. basis. 11. Colace 100 mg p.o. q.h.s. 12. An OBR.

SOCIAL HISTORY: The patient has a long history of tobacco but quit several years ago. He does not drink any alcohol. The patient is a retired coal miner and has no history of IV drug abuse.

FAMILY HISTORY: Family history is positive for diabetes in the patient's mother. The patient's father had a CVA; however, there is no family history of coronary artery disease in the family.

ADMISSION PHYSICAL EXAMINATION: The patient was an alert and pleasant, 63-year-old, white male in no apparent distress. Vitals: Temperature 36.7 degrees, blood pressure 132/74, heart rate 70, respiratory rate 20, saturations 93% on room air. HEENT: Pupils were equal and reactive to light and accommodation. Extraocular motions were intact. The oropharynx was clear without exudate or

Continued...

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Page: 1 of 3

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App.000330

Fax: 813-291-1100

123456;

10/25/99 2:28PM; JstFax #419; Page 3/4

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
DISCHARGE SUMMARY

Name: FITZWATER, JACKY
Med Rec: 1204422
Admission: 10/14/99
Discharge: 10/21/99

erythema. Neck: There was significant jugular venous distention, no carotid bruits. Carotid pulses were 2+ with normal upstrokes. Chest: There was diffuse expiratory wheezing with decreased breath sounds at the right base of one-third of the lung field. Cardiac: Regular rate and rhythm with a very precise aortic valve click. Extremities: There was 2+ pitting lower extremity edema to the knees bilaterally. Skin exam was normal. Neurological exam was nonfocal.

EKG on admission revealed normal sinus rhythm with a rate of 95, normal axis. There were Q waves present in leads V1 and V2. There was 1 mm of ST depression in leads V5-V6 as well as lead II. There were T-wave inversions present in leads V4-V6, I, aVL and II. Chest x-ray was notable for a large right pleural effusion.

ADMISSION LABORATORY DATA: Notable for a creatinine of 1.9. A chem-10 was, otherwise, normal. CBC revealed a white count of 7.7, hematocrit 37, platelets 282,000. PT 21.2 with an INR of 2.7, PTT 31.1.

HOSPITAL COURSE: The patient was admitted to the 4 east service for his continued shortness of breath and findings on exam suggestive of right heart failure, given the significant jugular venous distention and lower extremity pitting edema. It was felt that it would be necessary to do a cardiac catheterization; however, the patient was on Coumadin, and this could not be done right away. Thus, the patient was aggressively diuresed with some symptomatic improvement in his shortness of breath. The patient's Coumadin was stopped, and he was placed on IV heparin until his PT was at such a level that a cardiac catheterization could be done. The patient went to the cardiac catheterization lab on October 18, 1999. This revealed biventricular elevation of filling pressures with equalization of the diastolic pressures. The patient also was noted to have trace aortic insufficiency and mildly dilated aortic root on aortogram. Hemodynamics were all compatible with a constrictive physiology. Specifically, the patient's RV pressure was 45/12 with an RA pressure of 23, PA pressures of 44/23 and a wedge pressure of 24. The patient's constrictive physiology on cardiac catheterization was further worked up by an MRI which was done on October 19, 1999. This revealed pericardial thickening which was especially notable in the lateral free wall of the left ventricle. The thickness of the pericardium was measured to be between 0.5-0.6 cm. Again, the patient was noted to have left ventricular hypertrophy on the MRI, as he did on his echocardiogram done at Greenbrier Hospital. It was felt that the patient's constrictive pericarditis was probably a result of his prior surgery at the time of his aortic valve replacement. It was also believed that the patient could be managed medically and would not need surgery of his pericardium at this time. The patient continued to diurese through the remainder of his hospital course. He was comfortable walking around the ward on room air at discharge. The patient is stable at discharge.

Continued...

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Page: 2 of 3

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
DISCHARGE SUMMARY

Name: FITZWATER, JACKY
Med Rec: 1204422
Admission: 10/14/99
Discharge: 10/21/99

DISCHARGE MEDICATIONS: 1. Synthroid 0.2 mg p.o. q.d. 2. Metolazone 2.5 mg p.o. q.d. 3. Paxil 20 mg p.o. q.d. 4. Potassium chloride 20 mEq p.o. q.8h 5. Propafenone 150 mg p.o. b.i.d. 6. Colace 100 mg p.o. q.d. 7. Coumadin 5 mg p.o. q.d. 8. Prevacid 15 mg p.o. q.d. 9. Lasix 60 mg p.o. b.i.d. The patient will also go home on enoxaparin for a period of 2-3 days until he is therapeutic on his INR with a goal INR between 3-4.

DISCHARGE INSTRUCTIONS: The patient will followup with his primary physician, who is Dr. Lynn Smith, in a period of one week. He will need to have his INR checked in the next two to three days, and these results will be sent to Dr. Smith, such that she can decide when to stop the enoxaparin. The patient's INR on discharge is 2.1, so he should not need more than approximately 48 hours of enoxaparin until the goal INR of 3 is reached. The patient will also followup with Dr. Lawrence Gimple as needed.

Dictated by:

Signed by:

BURR HALL, M.D.
RESIDENT
DEPT OF INTERNAL MEDICINE

Date: _____
LAWRENCE W. GIMPLE, M.D.
ATTENDING
DEPT OF INTERNAL MEDICINE

BH/848 Job: 35488

D: 10/21/99 T: 10/21/99

cc: Dr. Lynn Smith, Rt. 2, Box 171, Lewisburg, Wv. 24901

COPY
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Page: 3 of 3

University of Virginia Health System

INVASIVE PROCEDURE REPORT

PATIENT DATA

DATE 10-18-1999	ACCOUNT	MRN 1204422	ROOM# UVA-B LAB		
PATIENT FITZWATER, JACKIE L		SSN	RACE Caucasian		
ADDRESS 1		ZIP	PHONE		
ADDRESS 2		INSURANCE			
GENDER Male	HEIGHT (IN) 69.0	HEIGHT (CM) 175	PID 99C-3138		
DOB 04-25-1936	AGE (YRS) 63	BSA (M2) 2.23	WEIGHT (LB) 240.0	WEIGHT (KG) 109.1	FLUORO (MIN) 7.1

LAB VALUES

HGB 10.2	HCT 31.3	WBC 7.0	PLT 1230	PT	INR	PTT 38.5	GLU 144	K+ 3.3	NA+ 144	BUN 20	CREAT 1.5
-------------	-------------	------------	-------------	----	-----	-------------	------------	-----------	------------	-----------	--------------

EVENT TIMES

PATIENT IN 11:57:17	READY 11:57:19	PHYS PAGED	BEGIN TIME 12:03:48	END TIME 12:47:04	PATIENT OUT 12:57:34
------------------------	-------------------	------------	------------------------	----------------------	-------------------------

PHYSICIAN/PROCEDURE

PHYSICIAN #1 Samady, Habib M.D.	PROCEDURE #1 CATH			
PHYSICIAN #2 Webb, Leslie M.D.	PROCEDURE #2			
PHYSICIAN #3	PROCEDURE #3			
REFERRING Gimple, Lawrence M.D.				
KNOWN ALLERGIES NKA				
CONTRAST #1 Omnipaque	USED #1 (CC) 125	CONTRAST #2	USED #2 (CC)	TOTAL (CC) 125.0

STAFF

SCRUB #1	CIRCULATE #1	RECORDER #1 Hostetter, Mary RN	NURSE #1 Brent, Myra RN	X-RAY #1 Vitanza, Jack RTR
SCRUB #2	CIRCULATE #2	RECORDER #2 Apperson, Sharon RN	NURSE #2	X-RAY #2

File: M1000288

FITZWATER, JACKIE L 1204422
Attending: Samady, Habib M.D.
University of Virginia Health System

Printed On: 10-18-1999 12:57:45

JAMES IV. 069

App.000333

HEMODYNAMICS

Name: FITZWATER, JACKIE L

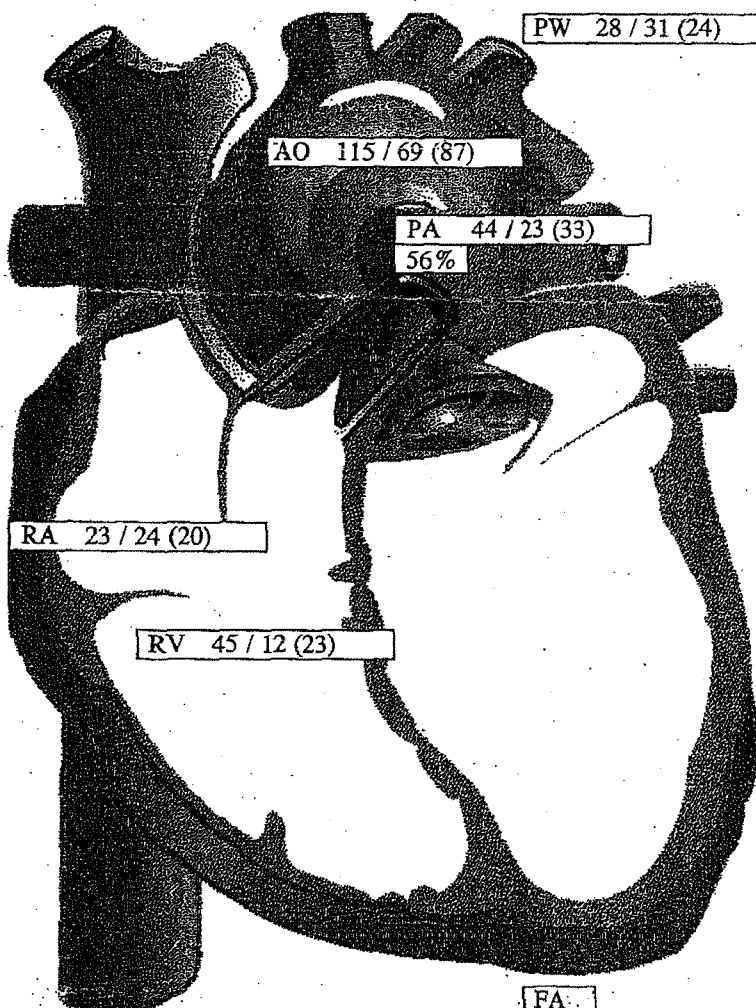
Date: 10-18-1999

MRN: 1204422

Proc: CATH

Cond(0): ROOM AIR REST

BSA: 2.23 m² Hgb: 10.2 K: 133 Est O₂: 296.59 cc



PW 28 / 31 (24)

Samples

ECG >	(6 Chan)	11:56:54
CO:	5.62 l/m	12:22:58
CO:	6.79 l/m	12:23:15
CO:	5.84 l/m	12:23:35
PW	28 / 31 (24)	PV 12:25:30
PA	44 / 23 (33)	PA 12:25:52
RV	45 / 12, 23	12:26:20
RA	23 / 24 (20)	SV 12:26:59
AO	115 / 69 (87)	SA 12:30:39
PA	56 %	PA
FA	88 %	PV

Morphology: NORMAL HEART

Resistance (D/S)	(D/S)
PVR:	118 264
TPVR:	434 968
SVR:	882 1966
TSVR:	1145 2553
PVR/SVR:	0.13
TPVR/TSVR:	0.38

O ₂ Content(cc/l)	O ₂ Difference(cc/l)
SA O ₂ : 122.07	SA-SV (AV): 44.39
SV O ₂ : 77.68	PV-PA (VA): 44.39
PV O ₂ : 122.07	PV-SV (VV): 44.39
PA O ₂ : 77.68	

Flows (l/min)
Qp: 6.08 Qpi: 2.73
Qs: 6.08 Qsi: 2.73
Qe: 6.68 Qei: 3.00
Qp/Qs: 1.00

CO(l/min)	SV(cc)	CI
Fick:	102.8 6.68	3.00
Thermal:	93.5 +6.08	2.73

Valve p-p mean msac HR cm² index

Angio LV RV

* Used In Calculations

CASE SYNOPSIS

Name: FITZWATER, JACKIE L**Date:** 10-18-1999**MRN:** 1204422**Proc:** CATH**Procedure**

Right Heart Cath
LCA Angiography
RCA Angiography
Aortogram

Medication(s)

12:01:16 IV drip: Heparin Drip d/c (by Brent, Myra RN)
12:03:26 Vallum 5 mg, IV-CATH (by Brent, Myra RN)
12:46:49 Nurse may pull sheath.

D-Equipment

{Catheters} Baxter 7 Fr./110cm. Swan Ganz Catheter
{Sheaths:} USCI Standard Sheath, 7 Fr. 11 cm,
{Accessories} Abbott Left Heart Pack
{Catheters} USCI 6 Fr./100cm. JL 4.0 cm Catheter
{Catheters} USCI 6 Fr./100cm. JR 4.0 cm Catheter
{Catheters} USCI 6 Fr. Straight Pigtail Catheter 110cm.
{Sheaths:} USCI Standard Sheath, 6 Fr. 11 cm,
{Guidewires:} USCI .035" 145 cm Fixed Core 3mm J Wire

Status/Urgency

Inpatient
Urgent

Findings/Diagnosis

Right Dominant, normal coronary arteries
Biventricular elevation of filling pressures, with equalization of diastolic pressures
Trace AI, mildly dilated aortic root on Aortogram
Hemodynamics compatible with constrictive physiology.

Complication(s)

No Complications in Lab

☒ I WAS PRESENT FOR THE ENTIRE PROCEDURE

I WAS PRESENT FOR THE CRITICAL PORTIONS OF THE PROCEDURE



(Samady, Habib M.D.)

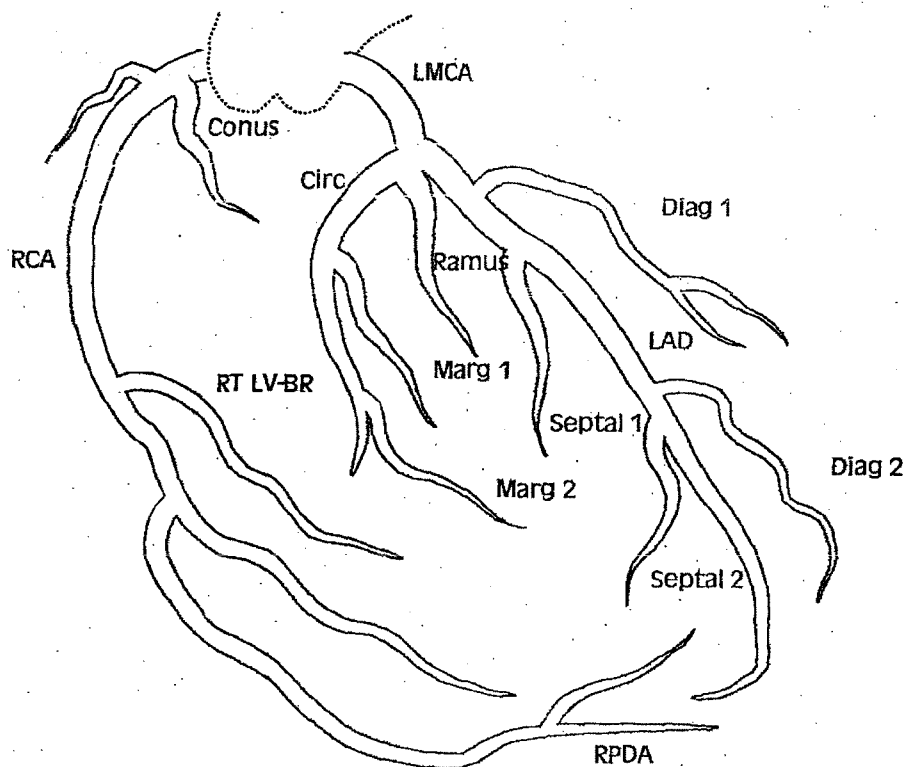
CORONARY TREE

Name: FITZWATER, JACKIE L

Date: 10-18-1999

MRN: 1204422

Proc: CATH



Findings

Diagnosis

Right Dominant
Biventricular elevation of filling pressures, with
equalization of diastolic
pressures
Trace AI, mildly dilated aortic root on Aortogram
Hemodynamics compatible with constrictive physiology

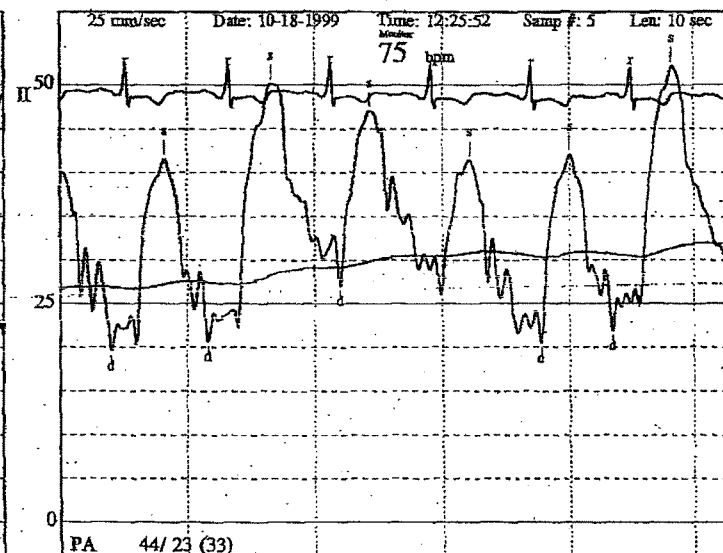
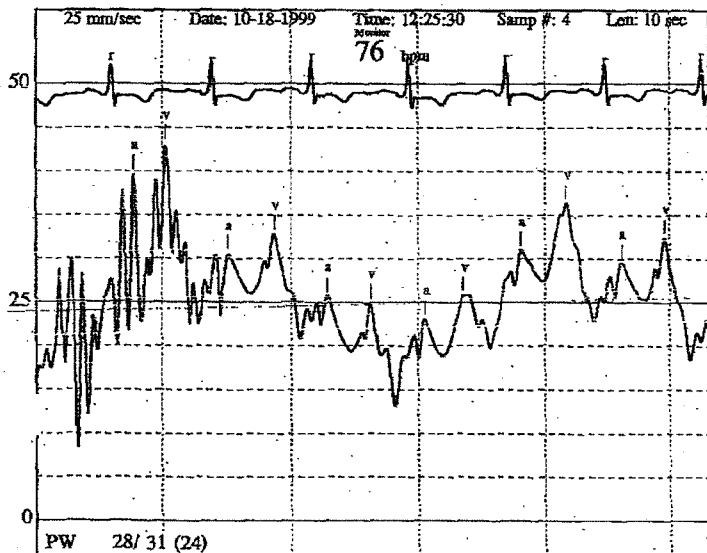
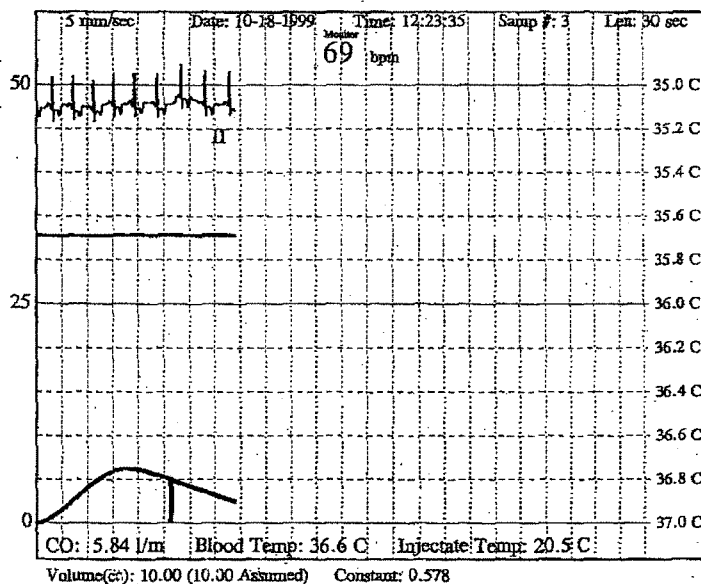
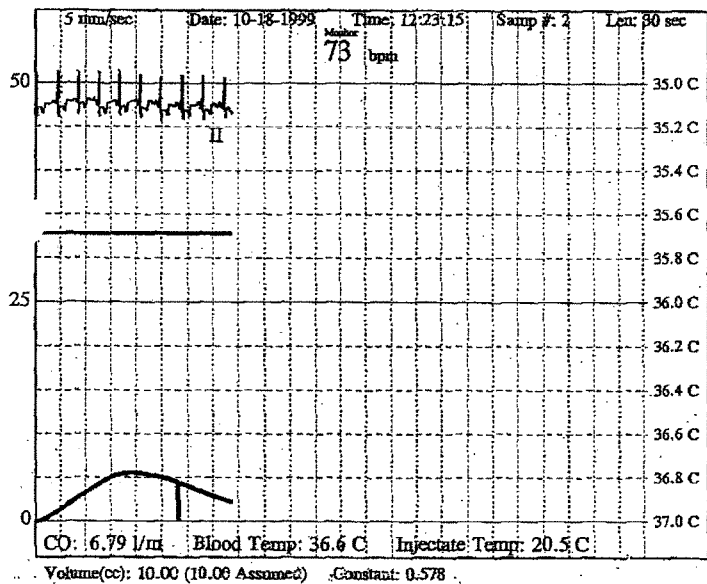
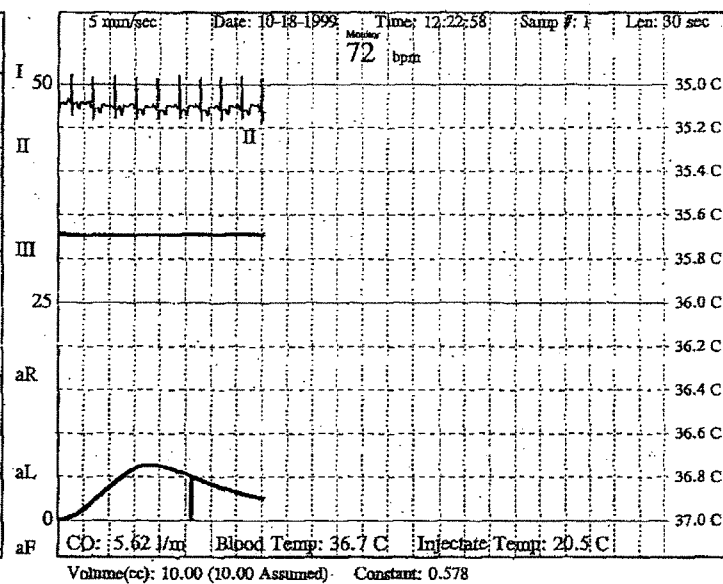
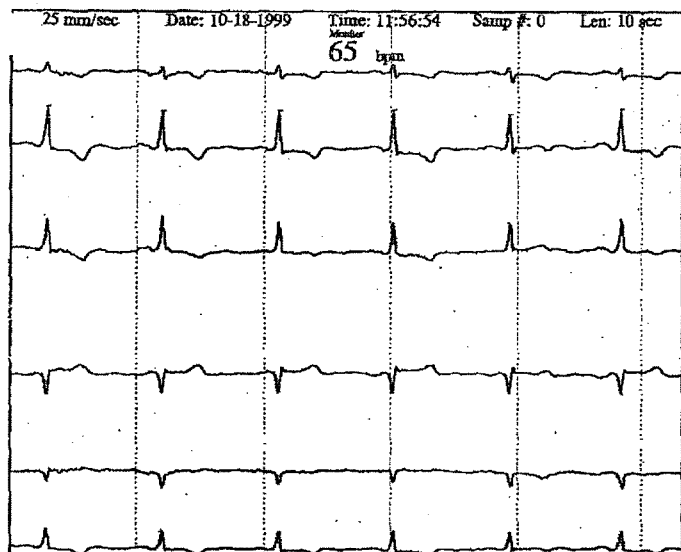
FITZWATER, JACKIE L

ID: 1204422

10-18-1999

Attending: Samady, Habib M.D.

Procedure: CATH



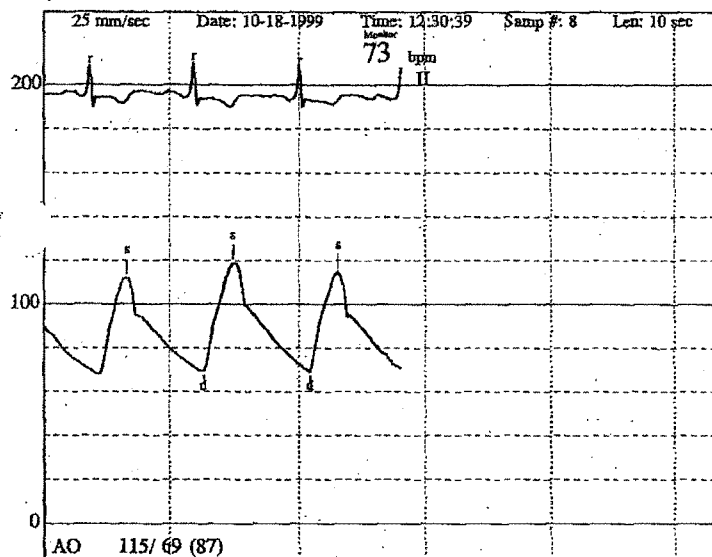
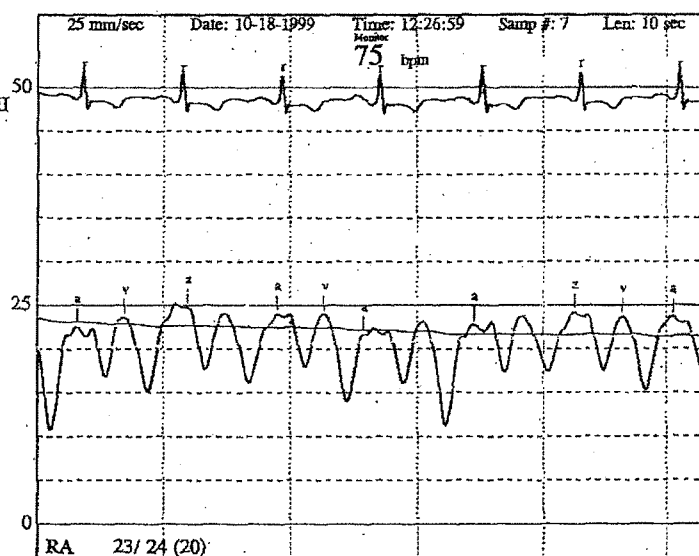
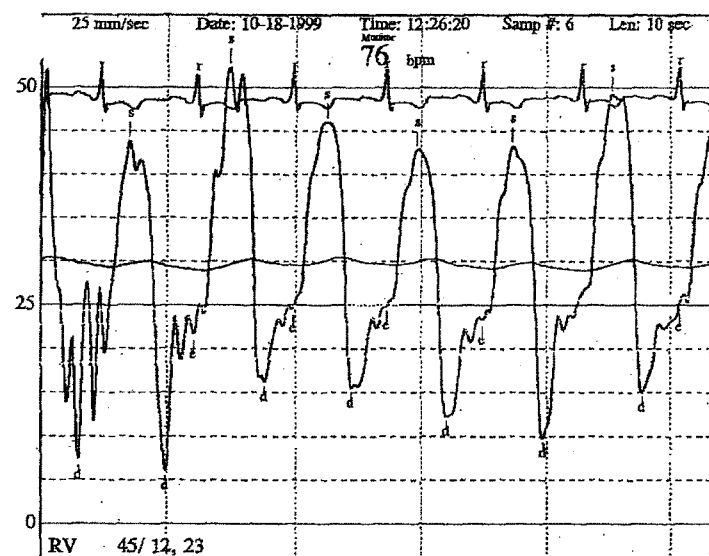
FITZWATER, JACKIE L

ID: 1204422

10-18-1999

Attending: Samady, Habib M.D.

Procedure: CATH



GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 10/11/99

DISCHARGE DATE: 10/14/99

ATTENDING PHYSICIAN: Dr. Lynn Smith

DISCHARGE DIAGNOSIS:

1. Biventricular congestive heart failure.
2. Chronic obstructive lung disease.
3. Hypothyroidism.
4. Sleep apnea.
5. Status-post aortic valve replacement secondary to rheumatic heart disease.
6. Questionable restrictive pericardial disease.
7. Diabetes, Type II with peripheral neuropathy.

DISPOSITION: The patient is being transferred at this time to the University of Virginia to the services of Dr. Larry Gimple for probable repeat cardiac catheterization to evaluate right sided pressures.

MEDICATIONS: Lasix 40 mg IV b.i.d. Zaroxolyn 2.5 mg qd. Paxil 20 mg hs. Levicid 15 mg qd. Coumadin 6 mg qd. Rhythmol 150 b.i.d. Synthroid 200 micrograms qd.

SUMMARY: This is a 63 year old gentleman with a history of valvular heart disease, status-post aortic valve replacement. Mr. Fitzwater over the last several months has been having increasing shortness of breath, peripheral edema, PND and right sided pleural effusion. The effusion was tapped and came back being transudate, consistent with congestive heart failure. Echocardiogram showed no evidence of significant valvular change. Normal functioning prosthetic valve with no evidence of LV dysfunction. Normal ejection fraction without evidence of pulmonary hypertension. His symptoms did improve with a thoracentesis however he continues to have increasing peripheral edema which has been unresponsive to outpatient therapy.

PAST MEDICAL HISTORY: Diabetes. Peripheral neuropathy. Borderline hypertension. Chronic lung disease. Sleep apnea. Hypothyroidism.

PHYSICAL EXAM: Alert, oriented, in moderate respiratory distress with any type of physical activity. At rest he was relatively comfortable. BP 120/70 without orthostasis. Pulse 88. Respirations 24. Weight 269. No JVD at 90 degrees. Very thick neck. Lung fields showed good aeration bilaterally. Decreased breath sounds on the right. Valve click with no diastolic component. 2-3+ pitting edema with sacral edema present.

HOSPITAL COURSE: It was felt that this gentleman again had recurrent congestive heart failure, questionable etiology. He was admitted to the PCU and was started on diuresis with IV Lasix and Zaroxolyn with significant improvement. This gentleman lost about 15-20 pounds during his hospital stay here. He felt much better, his shortness of breath improved. Ultrasound showed no evidence of ascites but evidence of pleural effusion. It was felt a question as to whether this gentleman had some

***** DISCHARGE SUMMARY *****

RECEIVED NOV 02 1999

Dictating Physician's copy

076
App.000340

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE: 10/11/99
ATTENDING PHYSICIAN: Dr. Lynn Smith

DOB: 04/25/36
DISCHARGE DATE: 10/14/99

UNIT #: D000038770

kind of restrictive cardiac process secondary to his previous valve surgery as the etiology of his heart failure. We were unable to prove that on echocardiogram. It was felt that re-evaluation by cardiac services was indicated. He was subsequently transported by ambulance to UVA for the purpose of repeat cath, probable right sided cath and determination if we could the etiology of this gentleman's failure.

Lynn Smith, M. D.

D: 10/28/99 0746
T: 10/30/99 1323
WJC

PMT, Inc. Job #: 1654

***** DISCHARGE SUMMARY *****

RECEIVED OCT 13 1999

GREENBRIER VALLEY MEDICAL CENTER

P.O. BOX 497

RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.PCU

UNIT #: D000038770

ADMISSION DATE: 10/11/99

ATTENDING PHYSICIAN: Dr. Lynn Smith

PATIENT PROFILE: This is a 63 year old with a history of valvular heart disease, history of early congestive heart failure and right sided effusion.

CHIEF COMPLAINT: Shortness of breath.

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater had the development of an effusion over the last several months. He had a valve replaced from a complication of rheumatic heart disease a couple of years ago. Significant increase in shortness of breath and peripheral edema without any real demonstrable cause. The fluid was subsequently tapped by Dr. Durham, pulmonary medicine, which came back as just transudate. His x-rays were most consistent with failure. He does have cardiomegaly with venous congestion. Echo showed no evidence of significant valvular change. He had a well functioning aortic prosthetic valve with no evidence of significant insufficiency. No evidence of pulmonary hypertension. He had some thickened LV function with some mild LVH but otherwise normal ejection fraction. After the thoracentesis he was doing well, had most of his symptoms relieved, his shortness of breath improved but over the weekend he became much more short of breath, really over about the last 48 hours. It was very difficult for him to catch his breath. No chest pain or pleuritic component to this. No PND or orthopnea. He has had significant peripheral edema problems which have been unresponsive so far to outpatient therapy.

PAST MEDICAL HISTORY: Diabetes. Known peripheral neuropathy. Borderline hypertension. Chronic obstructive lung disease. Known sleep apnea. No history of ulcers, kidney stones or history of cerebrovascular disease. Hypothyroidism.

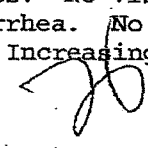
PAST SURGICAL HISTORY: Cholecystectomy. Appendectomy. Hand surgery. Valve replacement.

ALLERGIES: None known.

SOCIAL HISTORY: He has been a heavy smoker in the past and has quite for some time. No significant alcohol. Retired coal miner, worked there for over 40 years. No illicit drug use. Married and lives at home. He has two adult children.

FAMILY HISTORY: Unremarkable. His mother has a history of diabetes. His father died with a history of stroke. No premature heart disease in the family that we are aware of.

REVIEW OF SYSTEMS: Appetite has been good. His weight has been steadily climbing. No significant skin complaints or rashes. No visual changes or difficulty swallowing. No nausea, vomiting or diarrhea. No other GI symptoms. No dysuria or frequency. No difficulty in voiding. Increasing peripheral edema, steadily



GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: DG00036770

(Continued)

increasing. The remainder is related to his cardiopulmonary system.

PHYSICAL EXAM: Alert and oriented, dyspneic. Abdominal muscles are being used at this time. Respiratory rate 24. BP 120/70. Pulse 88. Weight 269. No scleral icterus is noted. Good normal fundoscopic exam. Extraocular movements are normal. Neck does not show JVD at 90 degrees. He has somewhat of a bull neck. Thyroid is not palpably enlarged. No significant adenopathy. Lung fields showed good aeration bilaterally. Decreased breath sounds at the right base. Regular rate and rhythm. Valve click, unchanged. Known diastolic murmur. No significant blunting of cardiac tones. Abdomen is markedly obese. Question as to whether it is ascitic fluid present. Cannot palpate the liver or spleen at this time. Extremities show 2-3+ edema bilaterally with chronic skin changes as well. No clubbing or cyanosis. Neuro, alert and oriented x 4. Cranial nerves within normal limits. DTR's 2+ with absent reflexes in his ankles. No evidence of any focal motor change. He can ambulate without difficulty on and off the table well and motor and sensory other than the distal sensory changes in his feet appear to be normal.

IMPRESSION:

1. Congestive failure, recurrent, questionable etiology.
2. Valvular heart disease.
3. Hypothyroidism, on replacement.
4. Sleep apnea.
5. COPD.

PLAN: Admit to progressive care unit with more aggressive

diuresis at this time. May consider further cardiac evaluation. Continue with his anticoagulation therapy. Routine lab, chest x-ray are to be done at this time.

Lynn Smith, M. D.

D: 10/11/99 1047

T: 10/11/99 1229

WJC

7885

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

OPERATIVE REPORT

NAME: FITZWATER, JACKIE L
ROOM #:

DOB: 04/25/36

UNIT #: D000038770

DATE OF OPERATION: 10/6/99

PREOPERATIVE DIAGNOSIS: 63 year old male with prosthetic heart valve who is currently anticoagulated who has a normal echocardiogram with a persistent and enlarging right pleural effusion, etiology unknown.

POSTOPERATIVE DIAGNOSIS: 63 year old male with prosthetic heart valve who is currently anticoagulated who has a normal echocardiogram with a persistent and enlarging right pleural effusion, etiology unknown.

OPERATION PERFORMED: Right diagnostic, therapeutic thoracentesis

SURGEON: Richard Durham, D.O.

ASSISTANT: Outpatient nursing staff

ANESTHESIA: Lidocaine 1% without epinephrine

FINDINGS: 1500 cc. of straw, somewhat cloudy pleural fluid was removed.

PROCEDURE: With the patient in the outpatient surgery department after appropriate consent was obtained, in a semi-sitting position, the right posterior thorax was palpated, prepped with Betadine and draped in a sterile fashion. Using Lidocaine 1% without epinephrine the skin, subcutaneous tissues and pleural space was anesthetized. Using Arrow catheter with needle thoracentesis set up catheter was placed in the right pleural space without difficulty, 1500 cc. of pleural fluid were removed. The catheter was then withdrawn. A sterile dressing was placed. A STAT portable chest x-ray is pending.

Richard R Durham, D.O.

D: 10/06/99 1335

T: 10/07/99 1052

JNM

7030

cc:

RECEIVED OCT 11 1999

Dictating Physician's copy

080
App.000344

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

10/6/99 268# 124/72 - P - 80

F/u

Edema

Jackie L. Fitzwater

10/06/99

Lynn Smith, M.D.

S: Jackie continues to have problems with the shortness of breath. Pulmonary services felt that this is most likely heart failure, even though he has normal LV function, valvular function, etc... on his echo. It is possible that it is diastolic dysfunction. He was started on **CARDIZEM** 120 a day but he has gained ten pounds fluid weight. He is having more dyspnea. No frank PND or orthopnea but still had a fairly large effusion.

PMH: He has known valvular heart disease, status post valve replacement. He has a history of some pulmonary hypertension, sleep apnea.

O: Physical Examination: On exam today, he still has dullness in the right lungs. He has increasing peripheral edema now, probably at least 2-3+. He says he it has been weeping on the right leg some. He has no change in his valve click and he has no diastolic murmur.

A: 1. Questionable increasing pulmonary hypertension and cor pulmonale. 2. Status post valve replacement. 3. Sleep apnea.

P: 1. We are going to add **ALDACTONE** 25mg twice a day to his current diuretic program. 2. Thyroid profile and CBC were drawn today. I have asked him to start weighing himself daily and he is going to contact us in 48 hours to see if we can't potentiate diuresis. If not, we may have to have him further evaluated back at the cardiology department at UVA.

L. Smith, D.O./mek/D: 10/06/99/T: 10/09/99

Valley Medical Associates, Inc.

Rt 2, Box 171

Davis Stuart Road

Lewisburg, WV 24901

(304) 645-3207

PAT NAME:

Jackie Fitzwater

E

WT

BP

PULSE

CC:

01/16/97 246 112/68 76 results of BE

for vac. given

WYETH FluShield® 497 82 02

Fitzwater, Jackie

10-16-97

L. N. Smith, M.D.

S: Jackie comes in today to go over his results. His echocardiogram does show some slight worsening of his valvular disease. He has moderate aortic stenosis, which is a little worse than the last year and a half. I've told him that we really have to watch this on an annual basis. He does have at least 2 gastric polyps, a hiatal hernia and some mild reflux. His symptoms are much better on the *Prilosec* but given his pernicious anemia history and his gastric polyps that is something that I do not think that we can ignore. They need to be monitored to make sure that there's no evidence of malignancy, given his increased risk.

A: Impression: 1. Gastric polyps. 2. B12 deficiency. 3. Aortic stenosis.

P: He will be scheduled for an endoscopy as soon as we can get it cleared through his insurance company. His flu shot is given today. Continue with the *Prilosec* therapy.
LNS/kls

PHONE CALL

FOR	Nurse	DATE	11-7	TIME	A.M. P.M.
M	Jackie Fitzwater				
OF					
PHONE	<input type="checkbox"/> FAX <input checked="" type="checkbox"/> MOBILE	438-6633			
		AREA CODE	NUMBER	EXTENSION	
MESSAGE					
Wants a Gastric polyp prescription - 11-24-97					
IT Refills Annual 2-24-97					
SIGNED					

11-10-97 Dr. Gomez Appt made - 11-24-97 2:45

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

12-8-98 - 247

100/62

80

follow up surgery

B-12 Dg. 2)

Jackie Fitzwater

12-8-98

Lynn N. Smith, M.D.

S: Jackie has had his aortic valve replaced. He has done well. He is now on Coumadin, is here to have this monitored, protime. He has not had any palpitations or chest pain. They have him on a Nicotrol patch because of having him stop smoking at this time.

O: Today he still has had some minimal rhonchi in his lungs. His valve is a St. Jude's valve and the click is very prominent, no diastolic component.

A: IMPRESSION:

1. Aortic stenosis, S/P prosthetic valve.
2. COPD.

P: We are going to have him continue with the Nicoderm patch, he is also on the Wellbutrin SR 150 mg bid. He is going to have his protime monitored as well as a CBC and a Ferritin level, continue with his Coumadin therapy and we will adjust the dosage after we see these results. LS/crw/T: 12-8-98

Terminal Drug **WHILE YOU WERE AWAY**

FOR Nurse DATE 12-14 TIME 9:00 (A.M. P.M.)

M _____

OF Jackie Fitzwater

PHONE ☐ FAX 438-6633 ☐ MOBILE

AREA CODE _____ NUMBER _____ EXTENSION _____

MESSAGE Continue Kelex - NO

last patch Continue Patches - yes

APPROVED _____
RECEIVED _____
RECEIVED _____
RECEIVED _____
RECEIVED _____
RECEIVED _____
RECEIVED _____
RECEIVED _____

12/14/98 RX called
to Terminal Drug
for Nicoderm
patches to RF
as directed per
LNS — SA, LP

JACKIE FITZWATER

12-10-98

LYNN SMITH, MD

I have contacted him today by phone. His labs look good with is hemoglobin and his Ferritin level being normal. His protime is excellent with an INR of 3.2.

IMP: 1. S/P valve replacement

PLAN: I have asked him to come in next week for a recheck on his Protime. He will continue with his current dosing schedule.

LS:pb

DEC, -07' 98 (MON) 11:02

P. 004



University of Virginia
HEALTH SYSTEM

Discharge Planning

PZ IDENTIFICATION

Fitzwater, Jackie Lee
1204422

TCV DISCHARGE PROGRESS NOTE

Date: 12/5/98

POD #: 6

Referring MD:

Lawrence Gimple

Attending MD:

Spotnitz

TCV Resident:

Arnold

Cardiologist:

Lawrence Gimple

Diagnosis:

Aortic Stenosis

Surgical Operation/Procedure:

Aortic valve replacement c 25mm mechanical St. Jude Valve.

Summary of Hospital Course - (include vital signs and complications, if any)

Mr. Fitzwater was taken to the operating room on 11/30/98, where he underwent AVR. He tolerated the procedure well. His post-operative course was unremarkable. He was extubated on POD#0. His pacing wires were removed and he began his anticoagulation c Coumadin on POD#1. He did well b/w POD#1-POD#3. On POD#2, he tolerated a regular diet. Throughout his hospital stay, he remained AF c stable VSS. His INR was therapeutic on POD#4.

Status at Discharge - (include surgical wounds and data list below)

Stable. Mr. Fitzwater was ambulating w assistance, reporting minimal oral analgesic, tolerating a regular diet. His wounds were c/d/I, x slight ooze from sternal chest wound.

Date/report last CXR: 12/1/98

Weight at discharge: 100.9 Kg.

Slight @ base atelectasis

OPTX

Pulse Oximeter %: 97 % RA

LAB RESULTS: date: 12/4/98

8.0 < 13.2 < 165
37.2

136, 95, 17 < 139 8.2
4.0, 33, 1.0 2.9
3.4

PT/INR: 19.9/2.8

TARGET = 2.5-3.0

Needs permanent
Anticoagulation

[Signature] 4584
MD Signature

DISCHARGE PLANNING

01428 (12/97)

DEC -09' 98(WED) 10:22

UVA HEALTH INFO SERVICES

TEL: 919-242883

P.002

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE LEE
Med Rec: 1204422
Admission: 11/30/98
Discharge: 12/05/98

ATTENDING PHYSICIAN: WILLIAM D. SPOTNITZ, M.D.
REFERRING PHYSICIAN: LAWRENCE W. GIMPLE, M.D.
DEPT OF INT CARD
PRIMARY CARE PHYSICIAN: ~~Lawrence W. Gimple, M.D.~~

PRINCIPAL DIAGNOSIS: Aortic stenosis.

PROCEDURES PERFORMED: Aortic valve replacement with 25 mm mechanical St. Jude valve.

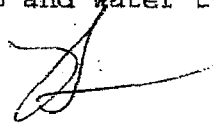
BRIEF HISTORY: Mr. Fitzwater is a 62-year-old man who is known to have a bicuspid and stenotic aortic valve. He recently has had increasing dyspnea on exertion and light headedness over the last six months. His physical exam and echocardiogram were consistent with aortic stenosis which is now symptomatic. He was admitted to the cardiothoracic surgery service under the care of Dr. Spotnitz for replacement of his aortic valve.

HOSPITAL COURSE: He was taken to the operating room on 11/30/98 where a mechanical St. Jude aortic valve was placed. He tolerated the procedure well and was taken to the PACU in stable condition. His postoperative course was uneventful. He was extubated on postoperative day number zero. His pacing wires and chest tubes were removed and he began his anticoagulation regimen with Coumadin on postoperative day number one. On postoperative day number two, he tolerated a regular diet. Between postoperative day one and three, he diuresed well with Lasix and on his own. His INR was therapeutic on postoperative day number four. Throughout his hospital stay, Mr. Fitzwater remained afebrile with stable vital signs.

DISCHARGE CONDITION: Stable. Mr. Fitzwater was ambulating without assistance, requiring minimal oral analgesics and tolerating a regular diet. His wounds were clean, dry and intact except for slight oozing from the inferior portion of his sternal chest wound. This was serosanguineous in color.

DISCHARGE MEDICATIONS: 1. Take Colace 100 mg 1 tablet b.i.d. as needed for constipation. 2. Omeprazole 20 mg 1 each morning before meals. 3. Synthroid tablet 0.15 mg take 1 q.d. each morning. 4. Vicodin 500 mg tablet 1 q.4-6h as needed for pain. 5. Warfarin tablet 5 mg 1 q.d. at h.s. 6. Wellbutrin SR 150 mg 1 q.d. q.a.m. x 2 days and then take 1 b.i.d. 7. Nicotine patch 21 mg apply one patch q.d.

DISCHARGE INSTRUCTIONS: 1. Heart healthy, low saturated fat, low cholesterol, reduced sodium, increase protein, no concentrated sweet diet. 2. Mr. Fitzwater may shower. He is not to take tub baths until the incision area has healed about two weeks. 3. No driving or lifting objects 10 lbs. or more for six weeks. 4. Clean incision with soap and water twice a day.



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Page: 1 of 2

085
App.000349

DEC. -09'98 (WED) 10:23

UVA HEALTH INFO SERVICES

TEL: 800-9242883

P.003

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
DISCHARGE SUMMARY

Name: FITZWATER, JACKIE LEE
Med Rec: 1204422
Admission: 11/30/98
Discharge: 12/05/98

FOLLOW UP APPOINTMENTS: 1. Dr. Lynn Smith on Tuesday 12/8/98. At this time a PT and INR is to be drawn. Therapeutic goal is 2.5-3. He should be receiving 5 of Coumadin q.d. p.m. Dr. Smith will manage Mr. Fitzwater's blood thinning medication. 2. Cardiology follow up appointment is to be scheduled with Dr. Lawrence Gimple prior to discharge. 3. To the TCV surgery office to see Dr. Spotnitz in six weeks. He will have a chest x-ray prior to this appointment.

Dictated by:

Signed by:

ABHINAV CHHABRA, M.D.
RESIDENT
SURGERY

WILLIAM D. SPOTNITZ, M.D.
ATTENDING
TCV SURGERY

AC/B47 Job: 14713

D: 12/05/98 T: 12/06/98

cc: Lynn Smith, M.D., Rt. 2, Box 171, Lewisburg, Wv 24901

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Page: 2 of 2

086
App.000350

DEC. -10 98 (THU) 09:13

UVA HEALTH INFO SERVICES

TEL: 804-924-2883

P. 002



December 4, 1998

Patient's Name: FITZWATER, JACKIE
Medical Record: 1204422

Lynn Smith, M.D.
Route 2, Box 171
Lewisburg, West Virginia 24901

Dear Dr. Smith:

This letter is to inform you of the progress of Jackie Fitzwater. As you know from previous correspondence, this is a 63-year-old white male patient with aortic stenosis. Surgery was arranged at UVA. On 11/30/98, he underwent an aortic valve replacement with a 25 mm St. Jude mechanical prosthesis without complications. His postoperative recovery was routine. He was begun on Coumadin for his mechanical valve. Discharge was set for around the weekend of 12/4/98.

Dr. Spotnitz will see this patient again in his clinic in the next two to three weeks. We would appreciate you following his prothrombin times, as he will need life-long Coumadin for his mechanical valve.

Thank you very much for this kind referral, and if you have any questions regarding this patient please do not hesitate to call the office at UVA.

Sincerely,

Charles B. Cox, P.A.
PHYSICIAN ASSISTANT
DEPT OF SURGERY

William D. Spotnitz, M.D.
ATTENDING
DEPT OF TCV SURGERY

CBC/802 D: 12/04/98 T: 12/05/98 Job: 14292

cc: Lawrence W. Gimple, M.D., Dept Of Internal Medicine, Box 158, Uva

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DEC. -10' 98 (THU) 12:04

UVA HEALTH INFO SERVICES

TEL: 804-924-2883

P. 002



December 7, 1998

Patient's Name: FITZWATER, JACKIE L.
Medical Record: 1204422

Lyn Smith, M.D.
Route 2, Box 171
Louisburg, West Virginia 24901

Dear Dr. Smith:

We would like to briefly update you regarding your patient Mr. Jackie Fitzwater. As you know, he is a 62-year-old gentleman with symptomatic aortic valve stenosis. He was evaluated by Dr. Lawrence Gimple in the Cardiology Department. An aortic valve area of approximately 0.7 cm squared was measured with a gradient of 100 mmHg.

Mr. Fitzwater was referred to the TCV Surgery Service for aortic valve replacement. He was admitted to the hospital on November 30 for a same day surgery aortic valve replacement. A St. Jude 25 mm mechanical valve was used. Operative findings confirmed congenital bicuspid aortic valve.

Postoperatively Mr. Fitzwater made good progress. He was started on Coumadin on the second postoperative day and this has been adjusted to a therapeutic range. He has had some serosanguineous drainage from the lower portion of his wound. Hopefully this will resolve.

He was discharged from the hospital on December 6, 1998. His discharge medications consist of: 1. Coumadin 5 mg and 7.5 mg on alternating days. 2. Cephalexin 500 mg four times a day for one week. 3. Synthroid 0.15 mg daily. 4. Bupropion sustained release tablet 150 mg daily as directed. 5. Nicotine patch 21 mg apply as directed. 6. Colace 100 mg twice daily. 7. Vicodin 1 or 2 tablets every four to six hours as needed for pain.

Mr. Fitzwater is scheduled to return for follow up in Dr. Spotnitz's clinic in six weeks. You will be receiving a note from Dr. Spotnitz when Mr. Fitzwater returns for that appointment.

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MEDICAL RECORDS BOX 476 CHARLOTTESVILLE, VIRGINIA 22908 804-924-6398

088
App.000352

DEC. -10' 98 (THU) 12:05

UVA HEALTH INFO SERVICES

TEL: 800-924-2883

P. 003

Patient's Name: FITZWATER, JACKIE L.
Medical Record: 1204422

Please let us know if we can be of any further assistance.

Sincerely,

Kenneth L. Blair, P.A.
PHYSICIAN ASSISTANT
DEPT OF SURGERY

William D. Spotnitz, M.D.
ATTENDING
DEPT OF TCV SURGERY

KLB/925 D: 12/07/98 T: 12/08/98 Job: 15221

cc: Lawrence W. Gimple, M.D., Uva Cardiology Service, Box 158

"COPY"
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DEC. -02'98(WED) 16:25

UVA HEALTH INFO SERVICES

TEL: 8049242883

P. 002

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
OPERATIVE REPORT

Name: FITZWATER, JACKIE
Med Rec: 1204422
Date of Surgery: 11/30/98

ATTENDING: WILLIAM D. SPOTNITZ, M.D.
SURGEON: WILLIAM D. SPOTNITZ, M.D.

RESIDENT: Scott Arnold, M.D.

ASSISTANT: Kenneth L. Blair, P.A.

PREOPERATIVE DIAGNOSIS: CRITICAL AORTIC STENOSIS.

POSTOPERATIVE DIAGNOSIS: CRITICAL AORTIC STENOSIS.

OPERATION: AORTIC VALVE REPLACEMENT WITH 35 MM ST. JUDE MECHANICAL PROSTHESIS.

ANESTHESIA: GENERAL ENDOTRACHEAL.

ANESTHESIOLOGIST: George Leisure, M.D.

HISTORY: The patient is a 62-year-old white male with a history of diabetes and COPD, who has been diagnosed with critical aortic stenosis by echo. Cardiac catheterization has demonstrated normal coronaries with documentation of his critical aortic stenosis. He has no other valvular abnormalities. He is brought to the operating room at this time for mechanical valve replacement.

PROCEDURE: Informed consent was obtained, and the patient was brought to the operating room and placed in supine position. General anesthesia was induced without difficulty, systemic antibiotics were administered. After sterile prep and drape, a median sternotomy was performed, while a transesophageal echocardiogram was being performed. The "TE" confirmed critical aortic stenosis with minimal "AI", no other valvular abnormalities. He had a thickened left ventricle with good function.

With the median sternotomy performed, the pericardial well was created. The aorta was of normal length and caliber and without any palpable abnormalities. Cannulation sutures were placed in the ascending aorta and right atrial appendage. A retrograde stitch was placed as was a right superior pulmonary vein vent stitch. The patient was heparinized and cannulated and placed on cardiopulmonary bypass without difficulty. A crossclamp was placed and the heart was arrested with antegrade and retrograde cold blood cardioplegia. We had good retrograde flow. The aorta was opened, and an oblique aortotomy was made and extended down into the noncoronary sinus. The aortic valve was identified. It was heavily calcified. It was a congenital bicuspid valve. The valve was excised without any trouble, and the annulus and outflow tract were copiously irrigated.

There was some calcification in the annulus, and this was debrided with a pituitary rongeur and further irrigation was performed. Next,

zf
COPY

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Page: 1 of 2

090
App.000354

DEC.-02'98 (WED) 16:26

UVA HEALTH INFO SERVICES

TEL: 804/242883

P. 000

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Medical Center
OPERATIVE REPORT

Name: FITZWATER, JACKIE
Med Rec: 1204422
Date of Surgery: 11/30/98

the valve was sized. It easily accepted a 25 mm St. Jude sizer. The valve was then sutured into place with everting 2-0 pledgeted Tycron sutures. The valve seated well. The aortotomy was closed in two layers with running 4-0 Prolene suture. The ventricle was then carefully de-aired using transesophageal echo while retrograde warm blood was administered. A hot shot was given. The patient resumed a spontaneous sinus rhythm. Prophylactic ventricular pacing wires were placed. He was weaned from cardiopulmonary bypass without difficulty. The de-airing process proceeded well. The vents were all removed. He was decannulated without difficulty. Hemostasis was adequate. Two chest tubes were placed and the chest was closed in the standard manner with interrupted wire sutures. There was one sternal fracture on the left side, and this was repaired with a figure-of-eight suture. The closure was otherwise uneventful with running 0 PDS in the fascia and further layers of absorbable suture. The patient tolerated the procedure well. All counts were correct. He received no blood products, and was transferred to recovery room in stable condition. Dr. Spotnitz was present in the operating room for this procedure.

Dictated by:

Signed by:

SCOTT ARNOLD, M.D.
RESIDENT
SURGERY

WILLIAM D. SPOTNITZ, M.D.
ATTENDING
TCV SURGERY

SA/805 Job: 12535

D: 11/30/98 T: 11/30/98

*Lawrence Simple**Lynn Smith*

COPY
DICTATED BUT NOT READ

Page: 2 of 2

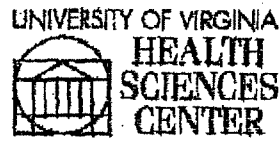
091
App.000355

DEC. -02' 98 (WED) 13:58

UVA HEALTH INFO SERVICES

TEL: 804-924-2883

P. 002



November 24, 1998

Patient's Name: FITZWATER, JACKIE
Medical Record: 1204422

Lynn Smith, M.D.
Greenbrier Valley Medical Center
Louisburg, West Virginia

Dear Lynn:

This letter is to provide you with follow up concerning Jackie Fitzwater. Please see also my previous letter of consultation. Mr. Fitzwater is a 62-year-old man who has been having progressive chest pain and shortness of breath. You had performed an echocardiogram which suggested critical aortic stenosis. He was therefore referred for cardiac catheterization.

He came to the Cath Lab on November 23, 1998. The aortic valve area calculated between 0.7 and 0.8 cm sq. He had approximately 50 mm gradient across the aortic valve. The aortic valve calcification could be seen on ventriculography. LV function was normal. The coronary arteries were clear.

I reviewed these findings with Dr. Bill Spotnitz of our Cardiac Surgical Service. Dr. Spotnitz did see Mr. Fitzwater and had a conversation with him about the surgery. At Mr. Fitzwater's request and due to the upcoming Thanksgiving holiday, his surgery was scheduled for Monday, November 30, 1998. Mr. Fitzwater will be returning to the University at that time for his aortic valve replacement.

I enjoyed taking care of Mr. Fitzwater. Please let me know if I can provide you with further information or assistance in his care.

Sincerely,

Lawrence W. Gimple, M.D.
ATTENDING
DEPT OF INT CARD

LWG/925 D: 11/24/98 T: 11/25/98 Job: 11496

University of Virginia Health Sciences Center
Cardiac Catheterization Laboratory
Charlottesville, Virginia 22908
(804-924-2736)

RIGHT AND LEFT HEART CATHETERIZATION

PATIENT NAME: Fitzwater, Jackie L

STUDY DATE: 11-23-1998

ADDRESS: P.O. Box 312

CITY: Quinwood

STATE: WV

ZIP CODE: 25981

HISTORY NUMBER: 1204422

DATE OF BIRTH: 04-25-1936

HT: 175.3 CMS. WT: 111.1 KGS.

B.S.A.: 2.25

GENDER: Male

RACE: Caucasian

REFERRING PHYSICIAN: Smith, Lynn M.D.

HOSPITAL ATTENDING: Gimple, Lawrence M.D.

PHYSICIAN PERFORMING STUDY: Lewis, Neil M.D.

ASSISTANTS: Matsumura, Martin M.D.

INDICATIONS:

Valvular Heart Disease

PRE-MEDICATIONS:

PROCEDURE(S):

Left Hrt Cath + Right Hrt Cath + Cor Art

LV-Gram

Cardiac Output

The patient underwent right and left heart catheterization. Percutaneous punctures of the right femoral artery and right femoral vein were performed following Xylocaine infiltration of the right groin. Catheters were placed in the pulmonary artery via the femoral vein and a retrograde catheter was advanced into the left ventricle via the femoral artery. Pressures were recorded in all of the chambers traversed. Simultaneous left ventricular and pulmonary capillary wedge pressures were recorded. Cardiac output was measured by the thermodilution technique. Blood samples were taken for oxygen saturation determination. A left ventriculogram was performed. Judkins catheters for the left and right coronary arteries were sequentially passed retrograde. Coronary arteriography was performed in multiple projections. Following completion of the procedure, hemostasis was obtained by pressure over the artery and vein.

CATHETERS USED:

RIGHT HEART:

7 FR. THERMODILUTION

7 FR. THERMODILUTION

LEFT HEART:

6 FR. JL4

6 FR. JR4

6 FR. PIGTAIL

6 FR. JL4

6 FR. JR4

6 FR. PIGTAIL

Fitzwater, Jackie L

HEMODYNAMICS:

PRESSURES (mmhg)	BASELINE	P-ANGIO	O2 % SAT	
			PRE	POST
SYS Art (s/d/m)	132/ 71/ 95	114/ 65/ 83	83	
Aorta (s/d/m)	140/ 81/101	124/ 65/ 87		
LV (s/bd/ed)	182/ 8/ 47	165/ 4/ 32		
RA (a/v/m)	22/ 17/ 17	/ /	63	
RV (a/v/m)	54/ 13/ 22	/ /		
PA (s/d/m)	38/ 27/ 31	/ /		
PCW (a/v/m)	27/ 29/ 24	/ /		
IVC (a/v/m)	/ /	/ /		
SVC (a/v/m)	/ /	/ /		
LA (a/v/m)	/ /	/ /		
PV (m)				

CARDIAC OUTPUTS/RESISTANCES

	BASELINE	P-ANGIO
HR (bpm)	64	69
FICK CO (L/min)		
FICK CI (L/min/m ²)		
THERMAL CO (L/min)	5.66	
THERMAL CI (L/min/m ²)	2.52	
SVR (dyne-sec/cm ²)	1343	
PVR (dyne-sec/cm ²)	466	

VALVE GRADIENTS/AREAS

AORTIC VALVE	BASELINE	P-ANGIO
MEAN GRADIENT (mmhg)		
SYS EJEC PER (sec/min)		
ORIFICE AREA (cm ²)		
ORIFICE INDEX (cm ² /m ²)		
MITRAL VALVE		
MEAN GRADIENT (mmhg)		
DIAS FILL PER (sec/min)		
ORIFICE AREA (cm ²)		
ORIFICE INDEX (cm ² /m ²)		

Fitzwater, Jackie L

LEFT VENTRICULAR ANGIOGRAPHY: Yes

RESULT: Normal

ANTEROBASAL: Normal
 APICAL: Normal
 POSTEROBASAL: Normal
 SEPTAL (APICAL): Normal
 INFEROLATERAL: Normal

ANTEROLATERAL: Normal
 DIAPHRAGMATIC: Normal
 SEPTAL (BASAL): Normal
 POSTEROLATERAL: Normal
 SUPEROLATERAL: Normal

LV VOLUMETRIC ANALYSIS:

EDV (ml)	
ESV (ml)	
LVEF	%

CORONARY ANATOMY

VESSEL	% STENOSIS	GRAFT	TYPE OF GRAFT	STATUS OF GRAFT

COMPLICATIONS:

None

ADDITIONAL COMMENTS:

Probable spasm of proximal RV wall
 branch of RCA. Ao V area 0.83 cm²,
 gradient 50mmHg.

CONCLUSION(S):

Significant Aortic Valve Stenosis



Lewis, Neil M.D.

NL :spc



The University of Virginia Health Sciences Center

Charlottesville, Virginia 22908

Lawrence W. Gimple, M.D.
Cardiovascular Division
Department of Internal Medicine
Box 158
(804) 924-9591
(804) 924-2581 FAX
E-mail: LGimple@virginia.edu

November 19, 1998

Lynn Smith, M.D.
Rt. 2, Box 171
Lewisburg, WV 24901

Patient: Fitzwater, Jackie L.
Record: 1204422

Dear Dr. Smith:

I had the pleasure of meeting your patient Jackie Fitzwater in the office today. He is well known to you. He is a 62 year old man who is known to have a bicuspid and stenotic aortic valve. This has been followed expectantly. He has recently been having increasing dyspnea on exertion and spell of lightheadedness. These have become worse over the last six months or so. He has not had true syncope or angina.

He was last seen at the University of Virginia by Marc Feldman about 4 years ago. At that time he had moderately narrowed aortic valve which was followed along. He does have a history of significant coal mine exposure and some shortness of breath on that basis. He does not have known coronary artery disease.

His past medical history is notable for diabetes. There is a history of spider bite with infection. He is s/p cholecystectomy. He is s/p appendectomy. He has had previous hand surgery. He is edentulous.

He has no known allergies.

Social history: He does continue to smoke rather heavily. He has a somewhat poor appetite by his report. He does not use illicit drugs. He is married and has two adult children. He works in the coal mines for over 40 years.

His family history is notable for the absence of hypertension or heart disease. There is no history of stroke. There is a history of diabetes in his mother.

His review of systems is notable for known AS as described. There is a history of black lung. There is a past history of duodenal ulcer. There is no known kidney disease or prostatic problem. There is a history of hiatal hernia by his report. He describes arthritis. There is rough dry skin. He has been hypothyroid in the past. All others are negative.

Page-2

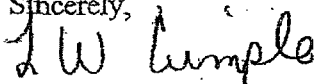
RE: Jackie Fitzwater

On physical exam he is well appearing. His blood pressure is 130/70. His heart rate is 70. His chest is clear. Cardiac exam reveals a flat JVP. There is S1 and S2. The aortic component of the second heart sound is diminished. There is a III/VI late peaking aortic murmur. Carotid upstrokes are delayed. His abdomen is benign and his extremities are without edema.

The EKG shows sinus rhythm and LVH.

In summary, Mr. Fitzwater has an exam and an echo consistent with AS which is now symptomatic. I will be checking a chest x-ray to evaluate how much of his shortness of breath might be related to his coal mine exposure. I do think that he has also has coexisting aortic stenosis and we will plan for cardiac catheterization in that regard. I discuss with him issues related to endocarditis as well as potential choice of future heart valves.

Sincerely,



Lawrence W. Gimple, MD
Cardiovascular Division

LWG/blb

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24801
(304) 845-3207

PATIENT NAME: _____

DATE

WT

BP

PULSE

CC: _____

PHONE CALL

FOR	Nurse		DATE	9/10	TIME	9:45	A.M. P.M.
M	Jackie Fitzwater						
OF	438-8633						
PHONE	<input type="checkbox"/> FAX	<input type="checkbox"/> MOBILE					
MESSAGE	AREA CODE	NUMBER	EXTENSION				
Needs script for Pulsecor - call in to Terminal Drug							
SIGNED							

FORM 4003

9/10/97
Pulsecor 2mg
#30 TGD CRF
Terminal KLM

9/10/1/97 WT 246 1/2 BT 130/08 P 80 CC ✓ hand Flu Refl
130/80 P-80
4 118/70 P-72
1 118/72 P-88

Fitzwater, Jackie

10-1-97

L. N. Smith, M.D.

S: Jackie comes in today for follow-up. We're still waiting to get the final decisions on treatment for his left carpal tunnel syndrome from his Workers Comp. He has problems when he stoops over and bends up and gets up, he gets very light headed and dizzy. It's been actually 2 years since his last evaluation of his aortic stenosis and he had moderate aortic stenosis at that time. He's not had any chest pain or failure or frank syncable episodes.

O: His exam still shows his murmur, poor carotid upstrokes. Lung fields are clear. No peripheral edema, other than some trace. He continues to have some early satiety symptoms although the dispeptic reflux symptoms have improved. With his B12 deficiency we are going to look closer and make sure that we're not seeing some gastric lesion.

P: Recheck his echocardiogram for follow-up of his aortic stenosis. An upper GI will be performed at this time. I'm not changing any medicines pending these results.

LNS/Kls

Jackie Fitzwater

WT 262

BP 140/80

P 80

a nausea / 3 weeks

01-16-96

Jackie Fitzwater 1-16-96

Dr. L. Smith

S: Jackie comes in today. His leg is still giving him about the same amount of problems. He didn't tolerate the higher Tegretol as it started giving him some itching so he cut down to just two tabs. a day which really I don't think enough for him.

O: He has had a mild tremor in his left hand for some time that he thinks has gotten worse. He has had some obstipation problems, both of which may be exacerbated by the increase in the Amitriptyline that we made last time. His sugars have been much better controlled and today PP is 134.

His lungs fields are clear. He has no change in his murmur. His aortic stenosis I think is stable. He has an intention tremor in the left arm, no cog-wheeling and no rest component. His leg is essentially unchanged.

A: Impression:

1. Diabetes, Type II.
2. Peripheral neuropathy.
3. Aortic stenosis.
4. Tremor, probable intention.

P: We are going to DC the Amitriptyline. We are going to increase his Tegretol to 200, 100, 200 dose for a total of 500 mg a day. He is going to go on Nasocort inhaler, one puff per each nostril twice a day (please note that he has had significant post nasal drainage which he believes is causing some morning nausea). He is going to contact me in about 10 days for follow-up. He is scheduled to go back within the next week to Roanoke to see his Neurologist and we will consider therapy for the tremor pending that evaluation. LNS/crw

Jackie Fitzwater

W- 258

SP 100/92

P 72

u

12-11-95

Jackie Fitzwater

12-11-95

Dr. L. Smith


S: Jackie comes back. His labs show that his Hgb.

O: A1-C level is still elevated. I believe that part of his problem is still his diabetes associated with his neuropathic complaints, as well as his polyuria and polydipsia. His Tegretol level was low and he has increased it up to 200 mg tid and he has seen some marginal improvement.

A: Impression:

1. Sleep apnea.
2. Valvular heart disease.
3. Peripheral neuropathy, post inflammatory.
4. Diabetes type II.

P: We are going to start him on Glucophage 500 mg twice a day with meals, increase his Amitriptylline to two at hs. We are going to monitor his sugars at home and will contact me in approximately a week for follow-up. LNS/crw

PHONE MESSAGE	TO	DATE	TIME	AM			
	FROM	12/20		PM			
	OF	Jackie Fitzwater	AREA CODE				
		438-06633	NO.				
		EXT.					
	154 BS AM						
							
	SIGNED						
	PHONED <input type="checkbox"/>	CALL BACK <input type="checkbox"/>	RETURNED CALL <input type="checkbox"/>	WANTS TO SEE YOU <input type="checkbox"/>	WILL CALL AGAIN <input type="checkbox"/>	WAS IN <input type="checkbox"/>	URGENT <input type="checkbox"/>

1/1/96 Glucophage 500mg BID #60 BOX 2 Terminated CA

Jackie Fitzwater

WT 265

BP 130/80

P 112

c/vp

Seg pressures

11-29-95

Seg pressures 11/30/95 9:00

Jackie Fitzwater 11-29-95

Dr. L. Smith

S: Jackie comes in today with actually a number of problems. He is still having problems with his neuropathy symptoms in his leg but he also has fairly typical exercise ischemic type of pain in his calf and thigh. He had segmental pressures done a year ago which showed evidence of moderate vascular disease with ABIs of about .7. He for some reason has not adjusted his medicine per Dr. Dawson's recommendation from his last visit in September. He has had not had any other follow up as far as his sugar is concerned as well and he still continues to have weight problems.

O: His exam shows really no major change. His lungs are clear. Cardiac is unchanged. His murmur is still present with his aortic stenosis. His legs are unchanged but his pulses are diminished, edema is about 1+.

A: Impression: 1. Diabetes, type II.
2. Aortic stenosis.
3. Atherosclerotic peripheral vascular disease with questionable claudication.
4. Peripheral neuropathy.

P: We are going to increase his Tegretol to 200 mg tid, going to keep him on his same dose of Amitriptyline. He is going to have his routine labs, Hgb. Al-C and Tegretol levels monitored at this time and will follow up as soon as these have been performed. Repeat segmental pressures will be obtained for comparison sake.

12-6-95 pt. called - (Tetracycline 500mg used for eye infection) Pt. has infection starting on arm from burn - called Keflex 250 # 21 for burn. - Tid x 14

Jackie Fitzwater

Wt 255 1/2 lb 12/62

p 86

✓ up, needs

Dawson 08-07-95 Aug 10 at 2:30 LHB Results
 Appt Dr. Wm ~~Ellis~~ Roanoke Neurological Center Sept 25 at 1:00

Jackie Fitzwater 8-7-95

Dr. L. Smith

S: Jackie is still having major problems with his legs. Hgb. A1-C level is minimally elevated at 6.4. I am sure the diabetes is at least a contributing factor. The glucose intolerance is a contributing factor to his neuropathy but he continues to have problems with this leg to the point that obviously we need to consider any other options.

At this time, I have explained to him that I really don't have much else to offer. We will increase his Tegretol to therapeutic levels but I want him to be seen by a neurologist to give us any other options to his leg.

A: Impression: 1. Peripheral neuropathy, post inflammatory.
 2. Glucose intolerance.
 3. Hypothyroidism.
 4. B-12 deficiency.
 5. Aortic stenosis.

P: We will refer him to the neurology group in Roanoke. He is due for a repeat echo at this time for monitoring his valvular heart disease. Increase Tegretol to 100 mg tid.

8-11-95 Dr. Dawson ↑ Tegretol to bid x 5 days then tid
 Called Terminal to let them know he needed
 Brand name BP

IN UNCOMPLICATED ACUTE HERPES ZOSTER FAMVIR (Famciclovir) SUCCESS WITH 300mg 3x/day 7 days		TELEGUARD™ DUPLICATE COPY PHYSICIAN MESSAGES For Doctor: Jackie Fitzwater Date: 8/11/95 Time: 11:30 AM Pharmacist: [blank] Allergies: [blank] Patient: 438-6633 MESSAGE: needs script Dawson ↑ Tegretol to bid x 5 days then tid (1 month release) Received by: [blank] Pharmacist: [blank] Nurse: [blank] Receptionist: [blank]	
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Thurs. 8/11/95
 1:30
 Echo
 Echocardiogram
 H H G V

has been upon

Jackie Fitzwater
6-30-95

Dr. L. Smith

S: Jackie is coming in, he is just having problems. He gets real tired and shaky, sweaty, this usually happens in the afternoon. It can occur when he is physically active. He just stays tired all the time and the question is whether the beta-blockade is the major contributing factor. He has had an occasional episode of chest discomfort which he says gets better with TUMS. He has had no real pain but it is more like "indigestion". This does not always appear to be exercise related and has significantly been relieved with the use of antacids.

O: His exam at this time is really unremarkable. No abdominal tenderness. Cardiac exam is normal. Peripheral edema is stable. Weight is stable.

A Impression: 1. Fatigue, possibly secondary to betablockade.
2. Chest discomfort, questionable etiology.

P: We are going to DC the Propranolol but I have advised him to watch very carefully for any change or acceleration of chest discomfort. I have given him a prescription for some Nitroglycerin to use if he gets that chest discomfort and it does not resolve with the use of antacids. He is going to contact me in 72 hours for follow up. He will contact me immediately if he starts having any worsening chest discomfort.

7-13-95 Synthroid 0.15 #30 Tg 1 2/2F Termedol
07-20-95 Wt 258 BP 142/86 P 58 W leg pain
Zantac 150mg 30 TMS
Tegretol 100mg #30 1/2 B.I.
Aspirin 325mg #30 Tg 1
3hpp BS-245
edema
scraps

Jackie Fitzwater 7-20-95

Dr. L. Smith

S: Jackie comes back for follow up, still having terrible problems with his neuropathic complaint in his right leg. He is improved with the Tegretol. This gentleman stopped the Glucotrol that we had him on and he had evidence of significant glucose intolerance and/or early diabetes which I think is also a contributing factor to his leg.

O: At this time his exam is unchanged. He does have still 1+ pitting edema bilaterally. No change otherwise.

A: Impression: 1. Neuropathic pain, secondary to post inflammatory, possible secondary to diabetes.

P: We are going to recheck his Hgb, A1-C and glucose today, increase his Tegretol to 100 mg bid. We will again if his sugars and Hgb, A1-C are abnormal, will get him started on something to try to get better diabetic management, as well as maximize his Tegretol therapy.

VALLEY MEDICAL ASSOCIATES, INC.

NAME Jackie F. [unclear]
 DATE 6/28/94
 REFERRING PHYSICIAN L. Smith, M.D.
 AGE 58 BSA [unclear]
 HEIGHT [unclear] WEIGHT 242 lbs.
 CLINICAL DIAGNOSIS Follow-up aortic stenosis

2 DIMENSIONAL TAPE # 12 (5007)
 IMAGE QUALITY [unclear]

M-MODE / SECTOR MEASUREMENTS:

1. LVEDD (3.7 - 5.6 cm < 3.2 cm/m ²)	<u>5.6</u>	2. LA (1.9 - 4.0 cm < 2.2 cm/m ²)	<u>3.3</u>
3. LVESD (2.2 - 4.0 cm)	<u>3.1</u>	4. RVIDD (.7 - 2.6 cm < 1.4 cm/m ²)	<u>[unclear]</u>
5. MAS (24 - 42%)	<u>[unclear]</u>	6. RVW (.3 - .9 cm)	<u>[unclear]</u>
7. MESS (≤ .9 cm)	<u>[unclear]</u>	8. Ao Root (2.0 - 3.7 cm < 2.2 cm/m ²)	<u>5.3</u>
9. LVIVS thickness (.6 - 1.2 cm)	<u>1.4</u>	10. Heart Rate:	<u>[unclear]</u>
11. LVPW thickness (.5 - 1.0 cm)	<u>1.5</u>	12. Est Ejection Fraction:	<u>[unclear]</u>
13. Est. mitral valve area by planimetry	<u>[unclear]</u>		

(*Measurement made in subxiphoid view)

DOPPLER:

	AoV	MV	TV	PV
Max. Velocity (m/sec)	14. <u>2.9</u> (1.0 - 1.7 m/sec)	15. <u>[unclear]</u> (.6 - 1.3 m/sec)	16. <u>[unclear]</u> (.3 - .7 m/sec)	17. <u>[unclear]</u> (.6 - .9 m/sec)
Gradient: Max:	18. <u>34</u>	19. <u>[unclear]</u>	20. <u>[unclear]</u>	21. <u>[unclear]</u>
(mmHg)	22. <u>17</u>	23. <u>[unclear]</u>	24. <u>[unclear]</u>	25. <u>[unclear]</u>
Regurgitation:	26. <u>[unclear]</u>	27. <u>[unclear]</u>	28. <u>[unclear]</u>	29. <u>[unclear]</u>
Area (cm ²):	30. <u>1.8 cm²</u> (3-4 cm ²)	31. <u>[unclear]</u> (4-6 cm ²)	32. <u>[unclear]</u> ()	
Pressure 1/2 time:		33. <u>[unclear]</u>	34. <u>[unclear]</u>	
35. PV Accel. Time:	<u>[unclear]</u> (nl. > 120m/sec.)	36. RV systolic pressure:		
37. C.O.: systematic:	<u>[unclear]</u> (nl. > 5 L/min)	38. Pulmonary	39. Qp:Qs	

INTERPRETATION: Echo/Sector/Doppler/LV Function

Two dimensional echocardiography reveals mild concentric left ventricular hypertrophy with normal systolic function. The left atrium, right atrium and right ventricle appear normal. The aortic root is mildly calcified. The aortic valve is calcified and appears restricted. There is cusp mobility noted. The valve may be bicuspid. The mitral and tricuspid valve appears normal. There is no evidence of pericardiac disease.

DOPPLER: Pulsed wave, continuous wave and color flow doppler reveal elevated aortic velocities with an estimated aortic valve area of 1.8 cm. sq. Mitral and tricuspid flows are normal.

CONCLUSION: Mild concentric left ventricular hypertrophy with normal systolic function. There is mild aortic stenosis and a probable bicuspid aortic valve. The estimated aortic valve area is 1.8 cm. sq. No other cardiac structural or flow abnormalities are detected.

VALLEY MEDICAL ASSOCIATES, INC.

NAME Jackie Fitz er
 DATE 7/6/94
 REFERRING PHYSICIAN L. Smith, M.D.
 AGE _____ BSA _____
 HEIGHT _____ WEIGHT _____
 CLINICAL DIAGNOSIS Possible endocarditis, check
vegetation and LV function
 2 DIMENSIONAL TAPE # 65 (0:14:34)
 IMAGE QUALITY Fair/Poor

M-MODE / SECTOR MEASUREMENTS:

1. LVEDD (3.7 - 5.6 cm < 3.2 cm/m ²)	<u>6.4</u>	2. LA (1.9 - 4.0 cm < 2.2 cm/m ²)	<u>4.5</u>
3. LVESD (2.2 - 4.0 cm)	<u>4.9</u>	4. RVIDD (.7 - 2.6 cm < 1.4 cm/m ²)	_____
5. MAS (24 - 42%)	_____	6. RVW (.3 - .9 cm)	_____
7. MESS (≤ .9 cm)	_____	8. Ao Root (2.0 - 3.7 cm < 2.2 cm/m ²)	<u>3.5</u>
9. LVIVS thickness (.6 - 1.2 cm)	<u>1.3</u>	10. Heart Rate:	_____
11. LVPW thickness (.5 - 1.0 cm)	<u>1.2</u>	12. Est Ejection Fraction:	_____
13. Est. mitral valve area by planimetry	_____		

(*Measurement made in subxiphoid view)

DOPPLER:

	AoV	MV	TV	PV
Max. Velocity (m/sec)	14. <u>2.6</u> (1.0 - 1.7 m/sec)	15. <u>.9</u> (.6 - 1.3 m/sec)	16. <u>.5</u> (.3 - .7 m/sec)	17. _____ (.6 - .9 m/sec)
Gradient (mmHg)	18. _____	19. _____	20. _____	21. _____
Regurgitation:	22. _____	23. _____	24. _____	25. _____
Area (cm ²):	26. <u>None</u> 30. <u>1.3 cm²</u> (3-4 cm ²)	27. <u>None</u> 31. _____ (4-6 cm ²)	28. <u>None</u> 32. _____ ()	29. _____
Pressure 1/2 time:		33. _____	34. _____	
35. PV Accel. Time: _____	(nl. > 120m/sec.)	36. RV systolic pressure: _____		
37. C.O.: systematic: _____	(nl. > 5 L/min)	38. Pulmonary _____	39. Qp:Qs _____	

INTERPRETATION: Echo/Sector/Doppler/LV Function

Technically difficult echocardiogram. Two dimensional echocardiography reveals mild concentric left ventricular hypertrophy with normal overall systolic function. The left atrium, right atrium and right ventricle appear normal. The aortic root appears normal. The left coronary cusp and the noncoronary cusp appear calcified and fused. There does appear to be mobility of the noncoronary cusp. There are no vegetations noted, although this cannot be excluded on this base of this study. The mitral and tricuspid valves appear normal. There is no evidence of pericardial disease.

DOPPLER: Pulsed wave, continuous wave and color flow doppler reveal elevated aortic systolic velocities at 2.6 m/sec. corresponding to a calculated aortic valve area of 1.3 cm. sq. There is no aortic insufficiency detected. The remainder of the doppler examination is unremarkable.

CONCLUSION:

Moderate aortic stenosis with a functional bicuspid aortic valve (calcified aortic valve as described above). There is no significant aortic insufficiency. There is mild concentric left ventricular hypertrophy. There are no other cardiac structural or functional anomalies noted. Vegetation cannot be excluded on the base of this study.

Patient Name Jackie Fitzwater Age 66 Date 12/12/02 Lynn N. Smith, M.D.
 Chief complaint 3wk F/U - Doris A. Ragsdale, M.D.

Jackie Fitzwater

December 13, 2002

Lynn N. Smith, M.D.

S: Jackie has done pretty well over the last month. He has a little sinus problem with some mild drainage, infection and a recurrent scalp infection. He also developed some cheilitis in the corners of his mouth. He has also developed a yeast again down in the groin region.

ROS: Weight is down about 4 lbs. Breathing is good. Appetite is good. No problems with the legs.

EXAMINATION: BP: 104/64. No evidence of any orthostasis. P: 96. WT: 255 lbs. He does have some areas in his scalp consistent with some folliculitis. He has some changes in the corners of his mouth. Lungs are clear. Valve clicks are unremarkable. He is still in his atrial fib with controlled rate. He has this woody induration with his peripheral edema still at about 1+ which is chronic for him but no evidence of any active cellulitis.

IMPRESSION:

1. Valvular heart disease s/p valve replacement.
2. Restrictive pericarditis.
3. Diabetes mellitus.
4. COPD.
5. Folliculitis.
6. Cheilitis.

PLAN: 1. We will get his labs drawn again. 2. We are constantly monitoring his BMP, protime. 3. We will put him on Doxycycline 100mg b.i.d. for a week and then 100mg q.d., Lotrisone b.i.d. for the rash. They will contact me if it is not improving and he will f/u in approximately one month.

L. Smith, M.D./sd/d: 12-13-02/t: 12-18-02

Ht _____ Wt 255 BP 104/64 Pulse 96 Temp _____ Resp _____

Vit. B-12
Ice Ins

EXAM

Normal

Abnormal

Comment

General _____
 Head _____
 Eyes _____
 Ears _____
 Nose _____
 Throat _____
 Neck _____
 Heart _____
 Breast _____
 Back _____
 Lungs _____
 Abdomen _____
 Extremities _____
 Skin _____
 Neuro _____
 Psych _____
 GYN/Rectal _____

LAB

AIC
 ALT/LIVER
 BMP-CMP
 CBC
 FLU
 HEMOCULT
 IRON
 LIPID
 MONO
 PAP/PSA
 PROTIME
 SED RATE
 STREPT CULT
 TSH
 UA/CULT
 URIC ACID
 VAG CULT
 ANEMIA PANEL
 HEP PANEL

IMPRESSION:

LAB RESULTS:

112/70 P-88
 124/80 P-88
 104/68 P-88
 PLAN:

Patient Name Jackie Fitzwater Age 66 Date 11/22/02 Lynn N. Smith, M.D.
 Chief complaint v up Doris A. Ragsdale, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 259 BP 110/62 Pulse 108 Temp _____ Resp _____

Vit B-12
1cc

EXAM

LAB AIC

Jackie Fitzwater

November 22, 2002

Lynn N. Smith, M.D.

S: Jackie is actually doing pretty well. He did have reflux and a lot of esophageal dysmotility problems but no gastric outlet problems. He has been put on Reglan before meals and is doing quite well. He is eating well with no nausea. He has actually gained some weight back since he has been eating more. Overall I think he is doing pretty well. His shortness of breath is stable. Peripheral edema is stable. No chest pain or palpitations. No infectious complications.

EXAMINATION: Lungs are clear. He has some valve click, still a little irregular and probably is atrial fib. He has his systolic murmur but no diastolic component. He has his 1-2+ edema which is unchanged. He has a little bit of a parotid enlargement bilaterally as well.

IMPRESSION:

1. History of toxic shock.
2. S/p valve replacement.
3. Restrictive pericarditis with corpulmonale.
4. Pneumoconiosis.
5. Diabetes mellitus.
6. Hypothyroidism.

PLAN: 1. We will get his BMP, TSH and protime today. 2. He is given B12 shot and will f/u in one month.
 L. Smith, M.D./sd/d: 11-22-02/t: 11-29-02

Patient Name Jackie Fitzwater Age 66 Date 11-11-02Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.Chief complaint vup -

Pertinent Past Medical History

Past Surgical History

Medications

GENERALWt Change _____
Fever _____
Chills _____
Sweats _____
HA _____
Weakness _____
Appetite _____**GENITOURINARY**Polyuria _____
Dysuria _____
Nocturia _____
Vag discharge _____
LMP _____**CARDIOVASCULAR**Chest Pain _____
SOB _____
Palpitation _____
Edema _____
HTN _____
PND _____
Orthopnea _____**MUSCULOSKELETAL**Arthralgia _____
Myalgia _____
Stiffness _____
Joint swelling _____
Injury _____**RESPIRATORY**Sputum _____
DOE _____
Pleurisy _____
Cough _____
Hay Fever _____
Asthma _____
Hemoptysis _____**SOCIAL HISTORY**Smoking _____
ETOH _____
Diet _____
Exercise _____**GASTROINTESTINAL**Abd Pain _____
Diarrhea _____
Constipation _____
Melena _____
Pain _____**ENT**Sore Throat _____
Ear Ache _____
Visual Chgs _____
Vertigo _____
Rhinitis _____**FAMILY HISTORY****PHYSICAL EXAM:**Ht _____ Wt 255 BP 114/52 Pulse 100 Temp _____ Resp _____

Jackie L. Fitzwater

November 11, 2002

Lynn N. Smith, M.D.

S: Jackie is back in for his f/u. He has done pretty well. His fluid is down about 5 lbs. He is having some early satiety problems. He says that he feels full, even a little nauseous after he eats. He has not really vomited, says that he has gagged once. He is still having normal, active bowel sounds and no pain. The question is whether this is some kind of motility disorder or possibly a structural problem. His breathing has been doing pretty good. He has had no chest pain or palpitations. W/in the last two weeks his labs were excellent as far as his protime, electrolytes. His potassium is still a little bit low but his hemoglobin has come up to 11.3 on the iron therapy.

EXAMINATION: Lungs are clear. He has his valve clicks which are unchanged. Abdominal: Obese. BS are normal and active. No tenderness, distension or palpable organomegaly. Extremities: He still has his 2+ edema which is unchanged.

IMPRESSION:

1. Early satiety, questionable etiology.
2. Diabetes mellitus.
3. S/p prosthetic valve with restrictive pericarditis.
4. Cor pulmonale.
5. History of toxic shock syndrome.

PLAN: 1. We will get an upper GI to look at his gastric emptying. 2. He is going to return on the 22nd which is his regular visit for his protime. 3. He will continue with his current medication management. 4. I have given him new prescriptions for now. I don't think that we need to do any other testing pending this evaluation.

L. Smith, M.D./sd/d: 11-11-02/t: 11-12-02

Patient Name Jackie Fitzwater Age _____ Date 10/28/02 Lynn N. Smith, M.D.
 Chief complaint F/U Labs Doris A. Ragsdale, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

Wt Change _____

Fever _____

Chills _____

Sweats _____

HA _____

Weakness _____

Appetite _____

GENITOURINARY

Polyuria _____

Dysuria _____

Nocturia _____

Vag discharge _____

LMP _____

CARDIOVASCULAR

Chest Pain _____

SOB _____

Palpitation _____

Edema _____

HTN _____

PND _____

Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____

Myalgia _____

Stiffness _____

Joint swelling _____

Injury _____

RESPIRATORY

Sputum _____

DOE _____

Pleurisy _____

Cough _____

Hay Fever _____

Asthma _____

Hemoptysis _____

SOCIAL HISTORY

Smoking _____

ETOH _____

Diet _____

Exercise _____

GASTROINTESTINAL

Abd Pain _____

Diarrhea _____

Constipation _____

Melena _____

Pain _____

ENT

Sore Throat _____

Ear Ache _____

Visual Chgs _____

Vertigo _____

Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____

Wt _____

BP 114/58

Pulse 84

Temp _____

Resp _____

Jackie Fitzwater

October 28, 2002

Lynn N. Smith, M.D.

S: Jackie is brought back in today. His numbers have really improved. His INR is back up to 3.4. His hemoglobin is up to 11.3. Potassium is still a little low at 3.2. He still feels tired a lot during the day but on questioning this gentleman really sleeps very poorly at night. He is up and down all night long, sometimes because of his diuretics, sometimes because he just does not sleep well. I think that he is still depressed and anxious and he has not done quite as well on the Paxil as we had liked.

EXAMINATION: He has a little bit of rales at the left base but otherwise is clear. Peripheral edema is improved. His weight is down about 4-5 lbs. BP holding good at 114 systolic. He has his valve clicks with no diastolic component to it.

IMPRESSION:

1. Anemia, improved.
2. Valvular heart disease s/p aortic valve replacement.
3. Depression.
4. Cor pulmonale with restrictive pericardial disease.

PLAN: 1. We will add some salt substitute to increase his potassium a little bit further. 2. We are going to shift his diuretics earlier to 7 and 4 so that hopefully when he goes to bed at 9 or 10 he is not having that effect. 3 We are going to d/c the Paxil and go to Zoloft at bedtime, 50mg. 4. I will see him back in a month but the family is going to monitor him closely and let me know if things are not improving.

L. Smith, M.D./sd/d: 10-28-02/t: 10-30-02

Patient Name Jackie Fitzwater Age 66 Date 10/24/02 Lynn N. Smith, M.D.
 Chief complaint S.d.B. Doris A. Ragsdale, M.D.

Pertinent Past Medical History

Past Surgical History

Medications

<u>GENERAL</u>	<u>CARDIOVASCULAR</u>	<u>RESPIRATORY</u>	<u>GASTROINTESTINAL</u>
Wt Change	Chest Pain	Sputum	Abd Pain
Fever	SOB	DOE	Diarrhea
Chills	Palpitation	Pleurisy	Constipation
Sweats	Edema	Cough	Melena
HA	HTN	Hay Fever	Pain
Weakness	PND	Asthma	
Appetite	Orthopnea	Hemoptysis	
<u>GENITOURINARY</u>	<u>MUSCULOSKELETAL</u>	<u>SOCIAL HISTORY</u>	<u>ENT</u>
Polyuria	Arthralgia	Smoking	Sore Throat
Dysuria	Myalgia	ETOH	Ear Ache
Nocturia	Stiffness	Diet	Visual Chgs
Vag discharge	Joint swelling	Exercise	Vertigo
LMP	Injury		Rhinitis

FAMILY HISTORY

PHYSICAL EXAM:

Ht Wt 260 1/2 BP 116/58 Pulse 100 Temp 98.3 Resp

Jackie Fitzwater

October 24, 2002

Lynn N. Smith, M.D.

S: Jackie is back in today for his f/u. His protime was a little low at 2.34 which is not where we want it given his prosthetic valve. He has not had any symptoms that would reflect any kind of neurological process. He has gained about 5 lbs in weight and is having some increase in swelling. He is still anemic with a hemoglobin of 9 but he is reticulating better and his iron levels were low. Stool hemocults were negative. Electrolytes are good. Renal function is back down to normal at 1.3. Potassium was slightly low at 3.2.

ROS: He has had a little more shortness of breath. He has had a cough now that has been productive of some yellow/brownish sputum. No fevers, chills or sweats. He has had some increasing peripheral edema. No bowel habit changes. One episode of nausea. Dig. level was noted to be slightly elevated at 1.9.

EXAMINATION: BP: 118/58. WT: 260.5 lbs. P: 100. Afebrile. He has no frank JVD at 45 degrees. Lungs are clear. He has his valve click with no new murmurs or gallops. He does have 2-3+ pitting edema. He has a mildly congested cough.

IMPRESSION:

1. S/p valve replacement with restrictive paracardial disease.
2. Cor pulmonale.
3. Anemia, iron-deficient. No evidence of active blood loss.
4. History of renal insufficiency, improved.

PLAN: 1. We will continue with his iron therapy. 2. We have increased his Coumadin to 6mg for the next two nights and then back to 5mg. 3. He will have a repeat on his protime, CBC and his electrolytes on Monday and will come by the office to go over those results. He is going to use daily weights at this time. 4. He is going to increase his Zaroxolyn to an every other day dosing until he loses a total of 7 lbs and then he will go back to an every 3-day dosing.

L. Smith, M.D./sd/d: 10-24-02/t: 10-25-02

Patient Name Jackie Fitzwater Age _____ Date 10/10/02 Lynn N. Smith, M.D.
 Chief complaint ER flu Doris A. Ragsdale, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELATAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Hi _____ Wt 255 BP 108/52 Pulse 88 Temp _____ Resp _____

Jackie Fitzwater

October 10, 2002

Lynn N. Smith, M.D.

S: Jackie is back in. He was converted back into a normal rhythm. He has been digitalized and has had only occasional complaints of palpitations since then. He is still somewhat weak. He has not been taking his iron nor did he check his stool hemocults as we requested after he left the hospital so I am not surprised that he is still feeling tired since he was anemic at the time. We adjusted his thyroid medication as well in the hospital so that needs to be monitored.

ROS: Appetite is good. He has had a little bit of increasing fluid retention. Minimal shortness of breath and cough but overall has done pretty good. He is still having some pain at the pacer site and up in the left shoulder.

EXAMINATION: WT: 255 lbs. BP: 108/52, P: 88 and regular. No JVD. Lungs are clear. He has 1+ pitting edema. The pucker appears to be well healed. No abdominal tenderness. He still appears to be pale.

IMPRESSION:

1. Sick sinus s/p permanent pacemaker.
2. Prosthetic valve s/p valve replacement.
3. Anemia.
4. Cor pulmonale with restrictive pericarditis.

PLAN: 1. We will recheck his CBC to make sure that that is not worse. 2. We will get some iron studies again. We will ask him to start on iron bid and to get his stool hemocults in. 3. His Dig. level, TSH will be monitored at this time as well. 4. F/u in one month.

L. Smith, M.D./sd/d: 10-10-02/t: 10-11-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie Fitzwater

October 3, 2002

Lynn N. Smith, M.D.

TELEPHONE CALL: I have talked to Jackie today. The Atenolol is still bothering him, making him short of breath and dizzy. We are going to d/c it at this time and digitalize him. We will start him on Lanoxin .25mg. He will take one, repeat it in four hours and stay on .25mg qd. We will draw the level in one week.
L. Smith, M.D./sd/d: 10-03-02/t: 10-07-02

Patient Name Jackie Fitzwater Age 66 Date 9-20-02
 Chief complaint Hosp R/O -

Lynn N. Smith, M.D.
 Doris A. Ragsdale, M.D.

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 248 1/2 BP 120/66 Pulse 84 Temp _____ Resp _____

Jackie Fitzwater

September 19, 2002

Lynn N. Smith, M.D.

S: Jackie was hospitalized with worsening failure. He was found to have evidence of tachy/brady syndrome and has had a permanent pacemaker put in. He has done well. His weight is down 20 lbs. He has probably had a flareup of his gout. His left ankle has been very sore and it has been difficult to walk since he has been home. His breathing has been good. Appetite is good. He still has some dermatological problems with these areas in his scalp that he tends to pick at and then get secondarily infected.

EXAMINATION: WT: 248.5 lbs. BP: 120/66, P: 84 and regular. A&O in NAD. No JVD. Lungs are clear. He has his valve click but no new diastolic murmur. He has 1+ edema which is good for him. The left ankle is a little bit warm and tender to touch. ROM is limited. No history of traumas or falls. There is no swelling in the MP joints or in the feet themselves. The pacer site looks well healed. No drainage at this time and dissolvable stitches are present.

IMPRESSION:

1. Severe restrictive cardiomyopathy with cor pulmonale.
2. Tachy/brady s/p permanent pacemaker.
3. Renal insufficiency.
4. Diabetes mellitus.
5. Probable gout.

PLAN: 1. We are going to draw his BMP and his protime. 2. I am going to give him some Celebrex 200mg just over the weekend until we get his labs back. 3. He will continue with his other medical management for now. 4. He will f/u in approximately one month. 5. Continue with daily weights.

L. Smith, M.D./sd/d: 9-19-02/t: 9-20-02

Patient Name Jackie Fitzwater Age 66 Date 8/30/02 Lynn N. Smith, M.D.
 Chief complaint V up Doris A. Ragsdale, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

Wt Change _____

Fever _____

Chills _____

Sweats _____

HA _____

Weakness _____

Appetite _____

GENITOURINARY

Polyuria _____

Dysuria _____

Nocturia _____

Vag discharge _____

LMP _____

CARDIOVASCULAR

Chest Pain _____

SOB _____

Palpitation _____

Edema _____

HTN _____

PND _____

Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____

Myalgia _____

Stiffness _____

Joint swelling _____

Injury _____

RESPIRATORY

Sputum _____

DOE _____

Pleurisy _____

Cough _____

Hay Fever _____

Asthma _____

Hemoptysis _____

SOCIAL HISTORY

Smoking _____

ETOH _____

Diet _____

Exercise _____

GASTROINTESTINAL

Abd Pain _____

Diarrhea _____

Constipation _____

Melena _____

Pain _____

ENT

Sore Throat _____

Ear Ache _____

Visual Chgs _____

Vertigo _____

Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 260 BP 100/58 Pulse 88 Temp _____ Resp _____

EXAM

LAB

Jackie Fitzwater

August 30, 2002

Lynn N. Smith, M.D.

S: Jackie is being admitted to the hospital today because of increasing congestive failure and 20 pounds in weight gain. Please refer to that admission note.

L. Smith, M.D./sd/d: 8-30-02/t: 9-03-02

Breast _____
 Back _____
 Lungs _____
 Abdomen _____
 Extremities _____
 Skin _____
 Neuro _____
 Psych _____
 GYN/Rectal _____

IMPRESSION:

PAP/PSA _____
 PROTIME _____
 SED RATE _____
 STREPT CULT _____
 TSH _____
 UA/CULT _____
 URIC ACID _____
 VAG CULT _____
 ANEMIA PANEL _____
 HEP PANEL _____

LAB RESULTS:

PLAN:

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE	WT	BP	PULSE	CC:
------	----	----	-------	-----

Jackie Fitzwater

August 2, 2002

Lynn N. Smith, M.D.

S: Jackie is back in for his f/u. He has actually done pretty well. I think that most of the inflammation in the legs has cleared. His shortness of breath has been good. His weight is down 9 lbs. He still has a lot of pain in his feet, especially in his left ankle when he is up walking. They have also noticed some significant problems with his balance. When he gets up and tries to walk he tends to stagger and almost falls. He has been using a cane but that has only been of limited benefit. This has been present ever since he has come home from the hospital.

ROS: Appetite is good. Weight is down 9 lbs. He has had no real shortness of breath or chest pains. No palpitations. No nausea, vomiting or diarrhea. He still has the pain in his legs and very sensitive to the skin. His neuropathy symptoms have been significant in his lower legs as well. His swelling has been under good control. He has had no other skin breakdown or rashes on his lower leg.

EXAMINATION: BP is excellent today at 138/82. Lungs are clear. He has his valve click which is unchanged. He is still obese. He has 2+ edema which is no different. I see no real evidence of any cellulitis now and it seems to be pretty well resolved. No erythema or heat in the legs at all. He has some osteoarthritic changes in his feet but no evidence of any acute inflammatory arthritis such as gout. He has marked abnormality with his balance. His gait disturbance is present. He has ataxia with a tendency to fall to the right. Positive Romberg's. His motor strength in upper and lower is unremarkable. Reflexes other than his neuropathic findings are unchanged.

IMPRESSION:

1. Ataxia, probably secondary to CNS event.
2. Renal insufficiency.
3. Recent cellulitis.
4. Cor pulmonale.
5. Valvular heart disease.
6. Diabetes mellitus.

PLAN: 1. We are going to get an MRI of his head to see if we have a cerebellar infarct. 2. His BMP, A1C and protime are drawn today. 3. We will stop his Keflex although he still has some on hand. 4. We will monitor his cellulitis symptoms for now. 5. We will bring him back as soon as these have been performed.

L. Smith, M.D./sd/d: 8-02-02/t: 8-02-02

Patient Name Jackie Fitzwater Age 73 Date 7/3/02
 Chief complaint F/u
on Keflex

Lynn N. Smith, M.D.
 Doris A. Ragsdale, M.D.

JACKIE L. FITZWATER
 FOLLOW-UP LEG CELLULITIS

7/3/02

Lynn N. Smith, M.D.

S: Jackie's leg continues to improve; still quite a bit of swelling, but the erythema and heat has gone down, and the cellulitis I think is clearing nicely. He has gained quite a bit of weight - some is fluid, some is where he is eating all the time, because he is not doing anything at home.

DATA: Potassium - was low at 2.9, and we have adjusted that dosage. Protime - slightly elevated at 4.3, but we are going to give it a little more time since he was on the higher doses before that was drawn.

ROS: Appetite has been good; no real chest pains or palpitations; minimal shortness of breath with activity; increasing neuropathy symptoms, especially at nighttime in both feet.

O: GENERAL: Obese. Weight is up to 246.

VITALS: BP: 130/82 (good).

LUNGS: Fields are clear.

CARDIAC: Valve click is unchanged with no diastolic murmur.

EXTREMITIES: Left leg is still slightly red and minimally warm, but much improved; still has quite a bit of peripheral edema that is pitting bilaterally; no new lesions noted.

FAMILY HISTORY:
PHYSICAL EXAM:

Ht 5'10" Wt 246 BP 118/70 Pulse 76 Temp 98.6 Resp 18

EXAM

Normal Abnormal Comment

LAB
AIC

IMPRESSION:

1. STATUS POST TOXIC SHOCK SYNDROME.
2. RENAL INSUFFICIENCY.
3. DIABETES.
4. CORONARY ARTERY DISEASE.
5. CELLULITIS - leg.

PLAN: (1) We are going to cut his Keflex to b.i.d. (2) Increase his Neurontin to 400 b.i.d. with his next dose at bedtime. (3) We will increase his Zaroxolyn 2.5 q3 days, instead of q4 days. (4) When he has his protime drawn in two weeks, we will also get a potassium and electrolytes checked at the time. (5) Follow-up in one month.

L.N. Smith, M.D./mek/D: 7-03-02/T: 7-09-02

Skin	_____	URIC ACID
Neuro	_____	VAG CULT
Psych	_____	ANEMIA PANEL
GYN/Rectal	_____	HEP PANEL

IMPRESSION:

LAB RESULTS:

PLAN:

Patient Name Jackie Fitzwater Age _____ Date 7/3/02 Lynn N. Smith, M.D.
 Chief complaint F/u _____ Doris A. Ragsdale, M.D.,
on Keflex

JACKIE L. FITZWATER
 FOLLOW-UP LEG CELLULITIS

7/3/02

Lynn N. Smith, M.D.

S: Jackie's leg continues to improve; still quite a bit of swelling, but the erythema and heat has gone down, and the cellulitis I think is clearing nicely. He has gained quite a bit of weight - some is fluid, some is where he is eating all the time, because he is not doing anything at home.

DATA: Potassium - was low at 2.9, and we have adjusted that dosage. Protime - slightly elevated at 4.3, but we are going to give it a little more time since he was on the higher doses before that was drawn.

ROS: Appetite has been good; no real chest pains or palpitations; minimal shortness of breath with activity; increasing neuropathy symptoms, especially at nighttime in both feet.

O: GENERAL: Obese. Weight is up to 246.

VITALS: BP: 130/82 (good).

LUNGS: Fields are clear.

CARDIAC: Valve click is unchanged with no diastolic murmur.

EXTREMITIES: Left leg is still slightly red and minimally warm, but much improved; still has quite a bit of peripheral edema that is pitting bilaterally; no new lesions noted.

FAMILY HISTORY:
PHYSICAL EXAM:

Ht _____ Wt 246 BP 118/70 Pulse 76 Temp _____ Resp _____

EXAM

Normal Abnormal Comment

LAB

AIC

IMPRESSION:

1. STATUS POST TOXIC SHOCK SYNDROME.
2. RENAL INSUFFICIENCY.
3. DIABETES.
4. CORONARY ARTERY DISEASE.
5. CELLULITIS - leg.

PLAN: (1) We are going to cut his Keflex to b.i.d. (2) Increase his Neurontin to 400 b.i.d. with his next dose at bedtime. (3) We will increase his Zaroxolyn 2.5 q3 days, instead of q4 days. (4) When he has his protime drawn in two weeks, we will also get a potassium and electrolytes checked at the time. (5) Follow-up in one month.

L.N. Smith, M.D./mek/D: 7-03-02/T: 7-09-02

Skin _____
 Neuro _____
 Psych _____
 GYN/Rectal _____

URIC ACID
 VAG CULT
 ANEMIA PANEL
 HEP PANEL

IMPRESSION:**LAB RESULTS:****PLAN:**

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

JACKIE FITZWATER
FOLLOW-UP LEG

6/26/02

Lynn N. Smith, M.D. _____

S: I think his leg overall is looking better. He mostly was complaining that it was still red, but I think that is really more of a dependent situation. The area on the posterior calf has already completely healed; the skin looks much better; the edema is about the same.

ROS: No significant symptom change; no fever, chills, or sweats; no chest pain or palpitations; no shortness of breath or frank PND or orthopnea.

O: VITALS: BP: 120/80 (good); P: 88.

CARDIAC: Valve click is unchanged; no diastolic component.

LUNGS: Fields are clear.

EXTREMITIES: Left leg is still erythematous, but is less noticeable; still some moderate warmth; a little swelling in that leg. The right one has cleared up very nicely.

We have reviewed all the other records and found that he does not have any significant other ongoing problems. This was a strep pyogenes as far as the infection, which was sensitive to all antibiotics.

IMPRESSION:

1. RECENT STREP SEPTOCEMIA.
2. ONGOING STREP CELLULITIS.
3. STATUS POST VALVE REPLACEMENT.
4. COPD.
5. DIABETES MELLITUS.

PLAN: (1) We are going to finish the **Augmentin** then switch him to **Keflex 500 q.i.d.** (2) He is going to continue with his current therapy with elevation. (3) We are going to see him back in about 10 days to continue monitoring this. (4) We have also started him on **Betadine** scrub once a week to decrease his bacterial counts on his skin.

L.N. Smith, M.D./mek/D: 6-26-02/T: 6-28-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC:

JACKIE FITZWATER
FOLLOW-UP LEG

6/26/02

Lynn N. Smith, M.D. _____

S: I think his leg overall is looking better. He mostly was complaining that it was still red, but I think that is really more of a dependent situation. The area on the posterior calf has already completely healed; the skin looks much better; the edema is about the same.

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LUNGS: Fields are clear.

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We have reviewed all the other records and found that he does not have any significant other ongoing problems. This was a strep pyogenes as far as the infection, which was sensitive to all antibiotics.

IMPRESSION:

1. RECENT STREP SEPTOCEMIA.
2. ONGOING STREP CELLULITIS.
3. STATUS POST VALVE REPLACEMENT.
4. COPD.
5. DIABETES MELLITUS.

PLAN: (1) We are going to finish the Augmentin then switch him to Keflex 500 q.i.d. (2) He is going to continue with his current therapy with elevation. (3) We are going to see him back in about 10 days to continue monitoring this. (4) We have also started him on ~~hydrocortisone~~ scrub once a week to decrease his bacterial counts on his skin.

L.N. Smith, M.D./mek/D: 6-26-02/T: 6-28-02

Patient Name Jackie Fitzwater Age _____ Date 6/11/02 Lynn N. Smith, M.D.

JACKIE FITZWATER

6/11/02

Lynn N. Smith, M.D.

S: Jackie was at Charlottesville with the toxic shock syndrome. He is following up at this time. We really do not have all the information on him yet. He is on longterm antibiotics because of the strep cellulitis in his leg. He did not have any kind of abscess. He had complications with renal failure, and actually has resolved pretty well with that.

ROS: Appetite has been fair; weight actually down about 30 pounds from his hospitalization; having no chest pain; shortness of breath is stable; still has some swelling in the leg with some pain in the leg - still red, and they were a little concerned about that. He has also had an area on the posterior aspect of the left calf that occurred because of him causing localized trauma by scratching.

O: GENERAL: He is alert and oriented, and actually looks pretty good for what he has been through. Weight 232.

VITALS: BP: 110/68; P: 76.

NECK: No JVD; thyroid not palpably enlarged.

LUNGS: Fields are clear.

CARDIAC: RRR; no murmurs, gallops, or rubs; does have his valve click with his aortic valve, and no diastolic component.

ABDOMEN: Still obese; no organomegaly or tenderness.

EXTREMITIES: Left leg is still swollen; very red and hot down below the knee. He has a small excoriated area on the posterior aspects of the calf, which is not draining, but was caused by localized trauma. There is still significant edema of that foot. The right one, which has been his chronic one, is actually a little bit better.

NEURO: He appears to be intact, alert, and oriented; no acute distress, and seems to be in full command.

PHYSICAL EXAM:

Ht _____ Wt 228 BP 108/64 Pulse 88 Temp _____ Resp _____

EXAM

Normal _____ Abnormal _____ Comment _____

General _____

LAB

AIC

ALT/LIVER

IMPRESSION:

1. STATUS POST TOXIC SHOCK SYNDROME.
2. VALVULAR HEART DISEASE - status post prosthetic valve.
3. CONTINUED CELLULITIS - leg.
4. COPD.
5. DIABETES MELLITUS.

PLAN: (1) We are going to continue with the **Augmentin** and check the sensitivities. (2) Will contact UVA to make sure that there is no other changes recommended by infectious disease. (3) Keep the leg elevated. (4) We will start whirl pooling the leg, and also try to stop him from picking at it at all. (5) He will follow-up in about a week.

LN. Smith, M.D./mek/D: 6-28-02/T: 7-01-02

Psych _____
GYN/Rectal _____

IMPRESSION:

URIC ACID
VAG CULT
ANEMIA PANEL
HEP PANEL

LAB RESULTS:

PLAN:

Patient Name

Jackie Fitzwater

Age

Date

6/11/02

Lynn N. Smith, M.D.

JACKIE FITZWATER**6/11/02****Lynn N. Smith, M.D.**

S: Jackie was at Charlottesville with the toxic shock syndrome. He is following up at this time. We really do not have all the information on him yet. He is on longterm antibiotics because of the strep cellulitis in his leg. He did not have any kind of abscess. He had complications with renal failure, and actually has resolved pretty well with that.

ROS: Appetite has been fair; weight actually down about 30 pounds from his hospitalization; having no chest pain; shortness of breath is stable; still has some swelling in the leg with some pain in the leg - still red, and they were a little concerned about that. He has also had an area on the posterior aspect of the left calf that occurred because of him causing localized trauma by scratching.

O: GENERAL: He is alert and oriented, and actually looks pretty good for what he has been through. Weight 232.

VITALS: BP: 110/68; P: 76.

NECK: No JVD; thyroid not palpably enlarged.

LUNGS: Fields are clear.

CARDIAC: RRR; no murmurs, gallops, or rubs; does have his valve click with his aortic valve, and no diastolic component.

ABDOMEN: Still obese; no organomegaly or tenderness.

EXTREMITIES: Left leg is still swollen; very red and hot down below the knee. He has a small excoriated area on the posterior aspects of the calf, which is not draining, but was caused by localized trauma. There is still significant edema of that foot. The right one, which has been his chronic one, is actually a little bit better.

NEURO: He appears to be intact, alert, and oriented; no acute distress, and seems to be in full command.

PHYSICAL EXAM:

Ht _____ Wt 228 BP 108/64 Pulse 88 Temp _____ Resp _____

EXAM

Normal

Abnormal

Comment

General

LAB

AIC

ALT/LIVER

IMPRESSION:

1. STATUS POST TOXIC SHOCK SYNDROME.
2. VALVULAR HEART DISEASE - status post prosthetic valve.
3. CONTINUED CELLULITIS - leg.
4. COPD.
5. DIABETES MELLITUS.

PLAN: (1) We are going to continue with the **Augmentin** and check the sensitivities. (2) Will contact UVA to make sure that there is no other changes recommended by infectious disease. (3) Keep the leg elevated. (4) We will start whirl pooling the leg, and also try to stop him from picking at it at all. (5) He will follow-up in about a week.

L.N. Smith, M.D./mek/D: 6-28-02/T: 7-01-02

Psych

GYN/Rectal

IMPRESSION:

URIC ACID

VAG CULT

ANEMIA PANEL

HEP PANEL

LAB RESULTS:**PLAN:**

Patient Name Jackie Fitzwater Age _____ Date 5/8/02 Lynn N. Smith, M.D.
 Chief complaint Cup - Doris A. Ragsdale, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 253 1/2 BP 114/66 Pulse 96 Temp _____ Resp _____

JACKIE FITZWATER
MED RENEWAL

5/8/02

Lynn N. Smith, M.D.

S: Jackie has done very well over the last month. He has very little shortness of breath. He has lost about 3-4 pounds in weight - activity level has improved. He says overall he has been feeling well. He has had one episode of palpitations, but no chest pain; has not had any real shortness of breath other than his usual dyspnea on exertion. He has had no PND or orthopnea. His peripheral edema has been under good control; no polyuria or polydipsia; denies any significant myalgia.

O: GENERAL: Weight 253 1/2.

VITALS: BP: 114/60; P: 70.

NECK: No JVD or thyroid enlargement.

CARDIAC: He has his valve clicks with his prosthetic aortic valve - unchanged; no other irregular rates.

LUNGS: Fields are clear.

EXTREMITIES: Trace peripheral edema.

SKIN: Chronic skin changes on lower legs - unchanged.

IMPRESSION:

1. VALVULAR HEART DISEASE - status post aortic valve replacement.
2. DIABETES MELLITUS.
3. COPD.
4. HYPOTHYROIDISM.
5. RESTRICTIVE PERICARDITIS.

PLAN: (1) We are going to get his labs including his protime, TSH, A1C, and BMP. (2) He is going to continue with his same medicines pending this with a follow-up for his monthly protime.

L.N. Smith, M.D./mek/D: 5-08-02/T: 5-11-02

App.000386

Patient Name Jackie Fitzwater Age 4/12/02 Date 4/12/02 Lynn N. Smith, M.D.
 Chief complaint 1 month F/U Doris A. Ragsdale, M.D.

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change _____
 Fever _____
 Chills _____
 Sweats _____
 HA _____
 Weakness _____
 Appetite _____

GENITOURINARY

Polyuria _____
 Dysuria _____
 Nocturia _____
 Vag discharge _____
 LMP _____

CARDIOVASCULAR

Chest Pain _____
 SOB _____
 Palpitation _____
 Edema _____
 HTN _____
 PND _____
 Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
 Myalgia _____
 Stiffness _____
 Joint swelling _____
 Injury _____

RESPIRATORY

Sputum _____
 DOE _____
 Pleurisy _____
 Cough _____
 Hay Fever _____
 Asthma _____
 Hemoptysis _____

SOCIAL HISTORY

Smoking _____
 ETOH _____
 Diet _____
 Exercise _____

GASTROINTESTINAL

Abd Pain _____
 Diarrhea _____
 Constipation _____
 Melena _____
 Pain _____

ENT

Sore Throat _____
 Ear Ache _____
 Visual Chgs _____
 Vertigo _____
 Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 257 BP 116/76 Pulse 80 Temp _____ Reso _____

JACKIE L. FITZWATER

4/12/02

Lynn N. Smith, M.D.

FOLLOW-UP

S: Jackie is doing very well. His weight is stabilized. His shortness of breath is good. His sugars have been down. He says he feels well. He still has some dyspnea on exertion, but overall his functions have been pretty good.

ROS: He has had no chest pains, palpitations, PND, nor orthopnea. He denies any change in his peripheral edema; no diarrhea.

O: VITALS: BP: 130/82 (good); P: 80.

NECK: No JVD; thyroid not enlarged.

LUNGS: Clear at this time.

CARDIAC: He has his valve click with a grade II systolic murmur, but no diastolic component; no S3 gallop.

EXTREMITIES: Trace-to-1+ pitting edema, which is normal for him.

IMPRESSION:

1. VALVULAR HEART DISEASE.
2. RESTRICTIVE PERICARDITIS.
3. COPD.
4. DIABETES MELLITIS.

PLAN: (1) Will draw his PT - INR was slightly low last time - we really wanted it to be between 3 and 4. He is now on 6 alternating 7mg. (2) He is going to continue with his other medications without change. (3) He will follow-up in approximately 1 month. (4) New prescriptions are given at 12:30 time. L.N. Smith, M.D./mek/D: 4-12-02/T: 4-17-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie L. Fitzwater

02-19-02

Lynn N. Smith, M.D.

S: Jackie is back in for his f/u. He is having a little dizziness. He has actually I think gotten too dry again. He has had all of his peripheral edema go away and he gets a little dizzy when he gets up and walks around. He is really not having any shortness of breath or PND at this time. His last INR was good at 3.25. He is off of the Diflucan so we can really readjust his Coumadin I think adequately.

ROS shows appetite has been good. No chest pains. No palpitations, PND or orthopnea. No dysuria, frequency. No nausea or vomiting or diarrhea.

EXAMINATION: BP: 118/68 but he does drop to 92/52 standing with a pulse that goes from 88 to 96. WT: 243 lbs. This is about 11 lbs less than what he was last time. No JVD. Thyroid is not enlarged. Lungs are clear. He has his valve clicks with no new diastolic murmur. No palpable peripheral edema at this time with good peripheral pulses.

IMPRESSION:

1. Restrictive pericarditis.
2. S/P prosthetic valve.
3. Volume depletion.
4. Hypothyroidism.

PLAN: 1. We will draw his protime and a BMP. 2. I have asked him to eliminate his Zaroxolyn altogether. On his scales, he weighed 247 lbs this morning so when he has a 5 lbs. weight gain over that he is going to take one of his Zaroxolyn as a booster tablet. 3. We are going to monitor closely his orthostatic symptoms at this time.

Lynn N. Smith, M.D./ssd/D: 02-19-02/T: 02-21-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie Fitzwater**02-04-02****Lynn N. Smith, M.D.**

S: Jackie is back in today. We called him on Friday when his INR was found to be very prolonged at 9. He has been off of the Coumadin. He has had some mild hematuria. He has had no other bleeding. He has had some dizziness which he describes as positional. When he moves his head a certain way the room starts moving with true vertigo. It is not orthostatic. He has had no further shortness of breath or chest complaints.

EXAMINATION: He is not pale. BP is good at 130/82. Pulse is regular. Lungs are clear. Cardiac shows his valve click which is unchanged. He has trace peripheral edema which is normal for him. On further questioning, we found out that he was started on Diflucan by his urologist for a presumed urinary tract problem and I am sure that since this started about one week ago that this is the drug interaction that we were looking for as far as to why this gentleman's protime was suddenly prolonged. There is a direct prolongation associated with the concomitant use of Diflucan.

His protime is being repeated along with his CBC.

IMPRESSION:

1. Coumadin toxicity believed secondary to concomitant drug administration with Diflucan.
2. Prosthetic valvular heart disease s/p aortic valve replacement.
3. Diabetes type II, improved control.
4. Restrictive pericarditis.

PLAN: 1. We are going to get a stat protime today and a CBC. 2. We will adjust his **Coumadin** downward. 3. A urinalysis will be obtained and we will monitor the hematuria which is most likely due to his Coumadin toxicity.

Lynn N. Smith, M.D./ssd/D: 02-04-02/T: 02-06-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie L. Fitzwater**01-31-02****Lynn N. Smith, M.D.**

S: Jackie is in today. He was recently hospitalized with an exacerbation of his heart and lung disease. Since going home his weight is down about 9 lbs. He has quit smoking which has been a major improvement. He says that he has been feeling well. He is slightly dizzy at times when he stands up but no chest pain, palpitations. No real shortness of breath. He does have some pitting edema. Appetite has been good.

Past medical history is significant for a restrictive pericarditis s/p aortic valve replacement. He has a history of pneumoconiosis, history of pulmonary hypertension, diabetes mellitus, hypothyroidism — all of which are on therapy.

ROS is unchanged from his HPI complaints.

EXAMINATION: Wt is down to 249 lbs. BP is 120/82, P: 80 and regular. No JVD or hepatojugular reflux. Thyroid is not enlarged. No cervical adenopathy. He has some mildly decreased breath sounds at his bases with no rales or rhonchi. Cardiac: He has his valve click with no new diastolic murmurs. No rubs or gallops. He is obese with no evidence of organomegaly. Extremities have 1+ pitting edema which is about normal for him and decreased pulses.

IMPRESSION:

1. Diabetes mellitus.
2. Valvular heart disease s/p valve replacement.
3. Restrictive pericarditis.
4. Pneumoconiosis.

PLAN: 1. We will have his BMP to monitor his electrolytes, his A1C level, TSH level drawn at this time. His protime will also be monitored.

Lynn N. Smith, M.D./ssd/D: 01-31-02/T: 02-01-02

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

Jackie L. Fitzwater**12-13-01****Lynn N. Smith, M.D.**

S: Jackie is back in for f/u. He is due for his repeat on his TSH and on his protime. He says he has been doing well. His weight has been stable. He continues to have some mild dyspnea on exertion but not much in the way of palpitations. He has been relatively active, still with some mild dyspnea on exertion. He has had very little problems with his legs as far as his neuropathic problems.

Past medical history is significant for known hypothyroidism, constrictive pericarditis s/p valve replacement for valvular heart disease, known COPD, history of hypokalemia secondary to diuretics. ROS shows weight has been stable. No other constitutional symptoms at this time. He denies any polyuria or polydipsia. He does have some excessive urination at times, when he uses his diuretics. He has had no cough or sputum production. No fevers or chills or night sweats. No nausea or vomiting or diarrhea.

EXAMINATION: His weight is stable, about ½ pound higher than before. The areas that we froze on his left temple have healed nicely from his skin lesions. Lungs are clear. He has his valve click which is unchanged with no new diastolic component. He still has about 1+ edema today and he states he has not taken his fluid medicine. He is obese. I cannot feel any palpable fluid waves or any organomegaly. He has no skin rashes other than some chronic dermatitis changes on his legs, lower legs bilaterally.

IMPRESSION:

1. Hypothyroidism.
2. Restrictive paracarditis.
3. Valvular heart disease.
4. Diabetes mellitus.

PLAN: 1. We will check his TSH at this time, his hemoglobin A1C and his potassium. 2. He has had his flu shot and pneumococcal vaccine. Again we have stressed for him to get his weight down. This gentleman also continues to smoke at this time and it is pretty obvious that he is not interested in quitting. Again we have recommended that to be done if at all possible.
Lynn N. Smith, M.D./ssd/D: 12-13-01/T: 12-18-01

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.309 UNIT #: D000038770
ADMISSION DATE: 07/12/01
ATTENDING PHYSICIAN: Dr. Lynn Smith

PATIENT PROFILE: This is a 65 year old gentleman with a history of restrictive pericarditis, history of congestive heart failure, COPD.

CHIEF COMPLAINT: Shortness of breath and increasing swelling.

HISTORY OF CHIEF COMPLAINT: Mr. Fitzwater has had a problem with recurrent congestive failure, cor pulmonale. He was hospitalized about two months ago where he was diuresed nicely; however, over the last week or so he has been having increasing shortness of breath, increasing peripheral edema. Even some periorbital puffiness associated with this and has gained about 18 pounds. He has had some frank PND orthopnea and progressive increasing dyspnea on exertion. He has had no cough or sputum production. He has had no history of any fevers, chills or sweats.

PAST MEDICAL HISTORY: He has a history of coal miner's pneumoconiosis. He has a history of type 2 diabetes, hypothyroidism, peptic ulcer disease, severe sleep apnea, cor pulmonale. He has history of rheumatic fever and aortic valvular heart disease.

PAST SURGICAL HISTORY: He has had history of aortic valve replacement. He has had a cardiectomy performed because of restrictive pericarditis. He has also had carpal tunnel syndrome bilaterally and a cholecystectomy.

SOCIAL HISTORY: He is married, lives at home with his wife. He is a retired coal miner. He smokes occasionally now. He used to completely not smoke but is now smoking at least one maybe two cigarettes a day. He has no significant alcohol history. He has no unusual diets and no regular exercise pattern.

FAMILY HISTORY: His mother died as a complication of diabetes. His father died because of a stroke. No history of any other major cancers.

REVIEW OF SYSTEMS: Shows that his appetite has been good. His weight is up 18 pounds since the last two months. He has had no skin rashes. He has had no difficulty swallowing. No visual or hearing changes. He denies any productive sputum. He has had no pleuritic chest pain. He has had no chest pain at this time. He has no nausea, vomiting, diarrhea. No bowel habit changes. No hematochezia. He has no dysuria, frequency. He does have difficulty in voiding with some hesitancy and known BPH. He has no complaints of any joint complaints or arthritis complaints other than his back. He has recent fall and hurt his right back about two weeks ago that he says has been getting progressively better. He has had no frank neurological symptoms although he does have numbness in his lower extremities associated with a no peripheral neuropathy. He also has a postinflammatory neuropathy in right leg associated with a previous aggressive strep infection.

RECEIVED JUL 15 2011

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

(Continued)

UNIT #: D000038770

PHYSICAL EXAM: BP is 108/60, weight is 271 1/2, respiratory rate 27 to 29. Pulse is 104. Patient is in moderate respiratory distress with significant dyspnea with minimal amount of exercise. Skin shows some ecchymotic areas on his arms. He has some actinic lesions on his forearms and his hands. He has some also in his scalp. HEENT: PERRLA. EOMI. Sclera and conjunctiva are unremarkable. No scleral icterus. TMs are clear. Posterior pharynx has some significant periorbital puffiness at this time. Funduscopic exam is normal. Posterior pharynx is clear with no obstruction. He has almost a bull(?) neck. Thyroid is not palpably enlarged. He has a positive hepatojugular reflux with no JVD at 45 degrees. His lungs show decreased breath sounds at the bases with bilateral rales to the lower scapular region. His cardiac shows a valvular click with a grade II systolic murmur. No diastolic component. No S3 gallop is audible. Abdomen is markedly obese. Bowel sounds are present in all four quadrants. No palpable masses or organomegaly, fluid wave or tenderness. Patient does have some early scrotal edema. His extremities show 3 to 4+ pitting edema up to the thighs. He has no palpable pulses because of this. He has decreased sensation bilaterally over lower legs with chronic stasis dermatitis changes. His joints show no evidence of heat or effusions. Neurological: Cranial nerves within normal limits. DTRs 2+ and symmetrical. He has absent ankle reflexes bilaterally. Motor strength is about 4/5. He has no other focal change at this time.

LABORATORY: Pending.

IMPRESSION:

1. Congestive heart failure with restrictive pericarditis.
2. Coal worker's pneumoconiosis.
3. Diabetes mellitus.
4. History of rheumatic valvular heart disease.
5. Hypothyroidism.

PLAN: He is admitted at this time. We will begin IV diuresis. I&Os and daily weights. We will reconsider for the possibility of thoracentesis if his pleural effusions have returned in a significant manner.

Lynn Smith, M.D.

D: 07/12/01 1946

T: 07/12/01 2034

WKG

PMT, Inc. Job #: 6207

RECEIVED JUL 15 2001

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 07/12/01

DISCHARGE DATE: 07/18/01

ATTENDING PHYSICIAN: Dr. Lynn Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure with cor pulmonale
2. Restrictive pericarditis
3. Coal Worker's Pneumoconiosis
4. Acute GI bleed secondary to gastric ulcer
5. Iron deficiency anemia
6. Diabetes mellitus
7. Status-post aortic valve replacement
8. Hypothyroidism

DISCHARGE MEDICATIONS: The patient is to resume his current home medications with the addition of iron sulfate 1 b.i.d., KCL 10 t.i.d., Coumadin 8 mg pm x 2 days and 7 mg per day. Prilosec 20 mg qd.

DISPOSITION: The patient is discharged home with a return appointment on Monday.

SUMMARY: This is a 65 year old with a history of restrictive pericarditis, congestive failure, COPD and having increasing problems with shortness of breath, increasing swelling and weakness. He has marked increase in peripheral edema and about an 18 pound weight gain. He had frank PND and orthopnea with progressive dyspnea. On presentation he was alert, oriented, still very weak and short of breath. His weight was 271 lbs. Respiratory rate was 29. Pulse 104. He had significant dyspnea with minimal exertion. No scleral icterus. Mild pallor was noted. Fundoscopic exam was normal. He had positive hepatojugular reflux but no obvious JVD at 45 degrees. Lungs show decreased breath sounds with bibasilar rales. He had 3+ pitting edema. Neurological was unremarkable.

HOSPITAL COURSE: The patient was admitted. Hemoglobin was found to be 8.9 with retic count of 5.5 with normochromic, normocytic indices. Stool was positive for blood. PT was minimally elevated at 5.5. The patient was subsequently transfused two units of packed cells where he began to feel better almost immediately. His Coumadin was withheld, it was not reversed because of his known prosthetic valve. He was begun on diuresis and actually did extremely well. He lost a significant amount of weight. His protime came down to about 3.8 with transfusions, his hemoglobin came up to 9.9. He began to feel better. He had some mild leg cramps secondary to hypokalemia that was corrected. He was seen in consultation by Dr. Jones. EGD was performed which did show a small gastric ulcer and some gastritis. He had a colonoscopy which was incomplete and a barium enema that showed no evidence of any other acute lesions. He had no further active bleeding. His protime did come down with an INR down to about 2.2 which was lower than we really wanted it to be. The patient was doing much better, was alert, walking. It was felt that perhaps a small ulcer was the source of his bleed and subsequent iron deficiency. He was subsequently discharged home in improved

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 07/12/01

DISCHARGE DATE: 07/18/01

ATTENDING PHYSICIAN: Dr. Lynn Smith

condition with adjustments made in his Coumadin. Will monitor closely his hemoglobin and his GI bleeding.

Lynn Smith, M. D.

D: 08/04/01 0913

T: 08/05/01 1133

WJC

PMT, Inc. Job #: 0499

***** DISCHARGE SUMMARY *****

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131
App.000395

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L. DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 05/08/01 DISCHARGE DATE: 05/14/01
ATTENDING PHYSICIAN: Dr. Lynn Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure with right pleural effusion.
2. History of restrictive pericarditis and cor pulmonale.
3. Status post aortic valve replacement.
4. Diabetes mellitus.
5. Hypothyroidism.
6. Pneumoconiosis.
7. Depression.

DISCHARGE MEDICATIONS:

1. Potassium 20 mEq p.o. t.i.d.
2. Demadex 100 mg p.o. b.i.d.
3. Zaroxolyn 2.5 mg q.o.d.
4. Synthroid 0.25 mg per day.
5. Flomax 0.4 mg q. day.
6. Coumadin 7 mg per day.
7. Glucotrol XL 5 mg per day.
8. Paxil 10 mg per day.

DISPOSITION: The patient is discharged home. Followup appointment in one week.

SUMMARY: Mr. Fitzwater is a 65 year old gentleman with known COPD, congestive heart failure and restrictive pericarditis who had begun having problems with increasing shortness of breath and increasing peripheral edema. We had tried on an outpatient basis to adjust his medications including the addition of Zaroxolyn, however, over the last week, he had put on 14 lbs of fluid and become more short of breath with PND and orthopnea. He had no chest pain. The patient has a history of coal workers' pneumoconiosis. He is status post aortic valve replacement with the complication of restrictive pericarditis.

PHYSICAL EXAM: He was in moderate respiratory distress with a respiratory rate of 26, BP 112/62 and weigh was up to 271 lbs with a dry weight of 253. Ruddy erythema of the face and puffiness and periorbital edema. Brief carotid upstrokes. He had bibasilar rales with decreased breath sounds. His valve click was unchanged with no diastolic murmur and a Grade II systolic murmur. He had no audible S3 gallops. The patient had 2 to 3+ pitting edema with sacral edema. Neurologically, he was alert and oriented.

HOSPITAL COURSE: The patient was admitted and was started on IV diuresis with fluid restriction. He began to feel better with increasing diuresis. His TSH was also

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 05/08/01

DISCHARGE DATE: 05/14/01

ATTENDING PHYSICIAN: Dr. Lynn Smith

noted to be 49 and his thyroid was increased at that time. The patient was doing better and with IV diuresis, his weight came down nicely and he did much better. His INR was adjusted and is slightly low ap. 2.83 with our goal being 3 to 3 1/2 given his prosthetic valve. Overall, he continued to do well with his diuresis, his shortness of breath improved and he had no other major complaints. We were able to get him close to where he normally was in the long run. With this, he was subsequently discharged home in improved condition to followup on an outpatient basis.

Lynn Smith, M.D.

D: 06/17/01 0730

T: 06/17/01 1250

VGC

PMT, INC. #1262

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***** DISCHARGE SUMMARY *****

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 64 SEX: M
ACCT: D00098179648 LOC: D.331 A
EXAM DATE: 01/05/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000213088 PORTABLE CHEST AP/PA ONLY,
000213086 PORTABLE CHEST AP/PA ONLY

CLINICAL HISTORY: PLEURAL EFFUSION
CHEST (1/4):

There is a small to moderate right pleural effusion. No pneumothorax is seen. There is moderate cardiomegaly. Underlying COPD is seen.

IMPRESSION: EFFUSION.

CHEST (1/5):

There remains an effusion on the right without significant change. No pneumothorax is seen. There is moderate cardiomegaly.

IMPRESSION: NO SIGNIFICANT CHANGE.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** Electronically Signed by Heather Rose M.D. on 01/05/2001 at 1112 **
Reported and Signed by: Heather Rose M.D.

CC: Lynn Smith, M.D.

Dictated Date/Time: 01/05/2001 (0607)

Technologist: Jackie C Cunningham RT(R)

Technologist: Ron W Cruse RT(R)

Transcribed Date/Time: 01/05/2001 (0923)

Transcriptionist: PMTLMC

Printed Date/Time: 01/05/2001 (1120) BATCH NO: 4875

PAGE 1

Lynn Smith, M.D.

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GREENBRIER VALLEY MEDICAL CENTER

P.O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

CONSULTATION REPORT

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

DOB: 04/25/36
ROOM #: D.331

DATE OF CONSULTATION: 1/4/01

ATTENDING PHYSICIAN: Lynn Smith, M.D.

CONSULTING PHYSICIAN: Richard Durham, D.O.

REASON FOR CONSULTATION: Therapeutic thoracentesis

HISTORY: The patient is a 64 year old white male who recently was discharged from the University of Virginia after undergoing pericardial stripping secondary to restrictive pericarditis. It is believed the patient developed this secondary to having prior surgery in which an aortic valve replacement was done on 11/3/98. The patient has had significant problems with pulmonary hypertension and cor pulmonale associated with it. According to Dr. Smith the patient left the hospital (UVA) at 238# and in the last 14 days has gained 12 pounds. He has had increasing shortness of breath, lower extremity edema, orthopnea. The patient states he felt like he was going to expire secondary to not being able to catch his breath. The patient denies any chest pain other than the mid sternal pain secondary to the recent surgery. The patient denies any fevers, chills, cough, productive sputum, nausea or vomiting.

He is currently on Warfarin therapy for his aortic valve replacement.

PAST MEDICAL HISTORY: Significant for aortic valve replacement, COPD, diabetes mellitus, type 2, coalworkers pneumoconiosis, obstructive sleep apnea, hypothyroidism, peptic ulcer disease, short episode of atrial fib after surgery in 1998, as well as having prior history of thoracentesis.

CURRENT MEDICATIONS: Include Synthroid 0.2 mg. q.d., Lasix 20 mg. q.d., Paxil 20 mg. one q.d., Combivent inhaler, Prilosec 20 mg. one q.d., Flomax one p.o. b.i.d. as well as using BIPAP unit for his sleep apnea.

SOCIAL HISTORY: The patient is a retired coal miner, has a 30+ pack year of tobacco use which he quite approximately two years ago. Denies any alcohol use. Denies any TB exposure.

REVIEW OF SYSTEMS: Denies seizures, headaches, diplopia, nausea, vomiting, melena, hematochezia, hemoptysis, hematemesis, hematuria, dysuria, change in voice or hoarseness. The patient has had some problems with sinus within the last couple of weeks, some epistaxis when blowing nose, increase in heartburn, dry mouth, increase in constipation since surgery, some bladder problems secondary to enlarged prostate, nocturia 4-5 times a night. States his hands feel weak in which he can't turn the pages of a magazine at times, rash both forearms which is stated to be a neurotic excoriation for which he was given an unknown salve which seemed to help.

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08 2004

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NAME: FITZWATER, JACKIE L
UNIT #: D000038770

PHYSICAL EXAM: Vital signs: blood pressure 120/60, pulse 92, respirations 24, temperature 99.7, weight 120 kilograms. General: He is normocephalic, atraumatic, PERL, BOMI. Nasal turbinates are erythematous and swollen, increased nasal drainage, posterior pharyngeal streaking is noted, mouth is moderately dry with geographic tongue noted, no cervical lymphadenopathy, no JVD, no carotid bruits or thyromegaly noted. Heart rate and rhythm are regular with S1 heart sound click noted secondary to valve replacement. No murmurs or gallops are noted. Respiratory: decreased breath sounds in the right lower and middle lobes. There are moderate crackles noted in the left lung. Abdomen is distended, obese with positive scar noted from the belt all the way to the sternal head. Abdomen is mildly tender in the right upper quadrant near the incision. Bowel sounds are positive in all four quadrants. I am unable to palpate any organomegaly. Extremities: there is +3 pitting edema up to the knees bilaterally. There are pigmented change noted in the skin bilaterally.

LABORATORY: ABG's revealed a pH of 7.46, PCO2-49, PO2-54, O2 sat 88.7% and FIO2 of 32. PT was 26.0, INR 3.95. TSH 16.37. Chest x-ray revealed a large amount of fluid in the right lung approximately up to the fourth, fifth rib. Cardiomegaly is noted. Surgical lines are noted in the sternal chest.

ASSESSMENT:

1. Right pleural effusion
2. Status post pericardial stripping
3. History of chronic obstructive pulmonary disease
4. Anemia
5. History of aortic prosthetic valve
6. Sleep anemia
7. Coalworkers pneumoconiosis
8. Hypothyroidism
9. Diabetes mellitus, type 2

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NAME: FITZWATER, JACKIE L
UNIT #: D000038770

PLAN: Therapeutic thoracentesis will be performed on the right lung. Cell count and diff will be performed on the pleural fluid. Will have an LDH, glucose, protein and cholesterol, gram stain, C&S, AFB and fungal C&S and cytology performed on the pleural fluid. Recommend CPAP with settings of 11 with 4 liters of O2. Portable chest x-ray will be performed after procedure. Recommend decrease Warfarin secondary to INR being 3.95.

Richard R Durham, D.O.

Dictated by Curran Jones, MS-IV

D: 01/04/01 1722
T: 01/04/01 2042
JNM

cc:

PMT, Inc. Job #: 4191

RECEIVED JAN 08 2001

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

OPERATIVE REPORT

NAME: FITZWATER, JACKIE L
ROOM #: D.331

DOB: 04/25/36

UNIT #: D000038770

DATE OF OPERATION: 1/4/01

PREOPERATIVE DIAGNOSIS: 64 old male who has had a history of a recurrent right pleural effusion secondary to complicated history including restrictive pericarditis with a recent pericardial stripping at the University of Virginia in 12/00. He has rheumatic heart disease, status post aortic valve replacement, currently anticoagulated. Cor pulmonale, sleep apnea, COPD.

POSTOPERATIVE DIAGNOSIS:

OPERATION PERFORMED: Therapeutic diagnostic thoracentesis

SURGEON: Richard Durham, D.O.

ASSISTANT: C. Jones, MS-IV

ANESTHESIA: Lidocaine 1% without epinephrine.

PROCEDURE: With the patient in semi-sitting position after appropriate consent was obtained the right posterior thorax was prepped with Betadine, dressed in sterile fashion. Using Lidocaine 1% without epinephrine skin and subcutaneous tissues and pleural space were anesthetized. Using an Arrow catheter over the needle of the thoracentesis kit, a catheter was placed in the right posterior thorax and 1460 cc. of a bloody fluid were removed without difficulty. The catheter was removed. Sterile dressing was placed and a STAT portable chest x-ray is pending. Appropriate studies have been sent.

Richard R Durham, D.O.

D: 01/04/01 1637

T: 01/04/01 1741

JNM

CC:

PMT, Inc. Job #: 4183

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GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
ROOM #: D.331
ADMISSION DATE: 01/04/01
ATTENDING PHYSICIAN: Dr. Lynn Smith

DOB: 04/25/36
UNIT #: D000038770

CHIEF COMPLAINT: Shortness of breath

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater is a 64 year old white female who recently underwent pericardial stripping, 12/20/00 at the University of Virginia because of restricted pericarditis. This developed post-operatively after he had a tricuspid valve replaced for rheumatic fever. He had significant problems with pulmonary hypertension and cor pulmonale associated with it. He went home at a dry weight of 238 lbs. Since being home over the last 10-14 days this gentleman has gained back up to 260 pounds, had significant increasing shortness of breath, PND, orthopnea and significant increasing peripheral edema. He has not had any other chest pain. He has not had cough or productive sputum. He had similar symptoms of this prior to his hospitalization with his restrictive heart disease problem.

PAST MEDICAL HISTORY: He has known rheumatic heart disease with valvular heart disease. Diabetes mellitus. History of hypertension. COPD. Pneumoconiosis. Obstructive sleep apnea. Hypothyroidism. He has known peripheral neuropathy. History of paroxysmal atrial fibrillation in the past.

PAST SURGICAL HISTORY: Aortic valve replacement. Cholecystectomy. Circumcision. Carpal tunnel. Cardotomy performed recently.

MEDICATIONS: His current medications include Synthroid .2 qd. He has only been on Lasix 20 mg qd. Coumadin 7 mg qd. Paxil. Combivent. Prilosec. He has also been on Flomax because of his BPH and history of nebulizers. He also has a home CPAP unit that he has been on for his sleep apnea.

SOCIAL HISTORY: He is a retired coal miner. He is currently married and lives at home with his wife. He has no significant cigarette history. He has a longstanding history of tobacco use but hasn't smoked in a number of years.

FAMILY HISTORY: Positive for atherosclerotic vascular disease with his father dying of a stroke and his mother having a history of diabetes.

REVIEW OF SYSTEMS: His prostatism has been fairly well controlled. He has no fever, chills, sweats, nausea, vomiting or diarrhea. Appetite has been good. He has had no chest pain, no skin rashes, no evidence of any bleeding, melana or hematochezia.

PHYSICAL EXAM: The patient is alert and oriented. He is extremely short of breath sitting. Weight 266 with BP of 196/54. Pulse 120. O2 sat is 85% on 2 liters of nasal O2. He has no evidence of JVD but he can only get at about 45 degrees. He has also a very bull neck. Pupils are equal and reactive. Sclera and conjunctiva are within normal limits. Normal fundoscopic exam. Posterior pharynx is clear with bilateral

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

plates. He has no thyroid enlargement, good carotid upstrokes and no adenopathy. His lungs showed decreased breath sounds throughout the right lung, no rales in the left. He has no E to A changes. Cardiac shows a regular rate and rhythm with valve clicks and a mild Grade II systolic murmur. No diastolic component. No S-3 gallop. Abdomen is obese. Bowel sounds are active. He still has a small draining site at his upper abdomen consistent with previous drain. There is only minimal drainage on the bandage at this time. He has no palpable organomegaly. No palpable ascites. No tenderness. We are unable to do a rectal exam because the patient cannot lie flat at this time. He has 2+ to 3+ pitting edema bilaterally. Pulses are not palpable distally. He has chronic skin changes on his legs consistent with a previous lymphedema and chronic swelling. Neurologically he is alert and oriented x 4. Cranial nerves are unremarkable. DTR's are 2+ except for knees and ankles which are absent. He is ambulatory at this time without assistance. Gait and tandem appear to be normal. He has no evidence of focal motor change.

LABORATORY: Chest x-ray shows a large right pleural effusion. Hemoglobin 8.1. Creatinine 1.8 with a BUN of 29.

IMPRESSION:

1. Symptomatic pleural effusion, questionable post-cardiotomy vs recurrent cor pulmonale
2. Anemia
3. Prostatic valve
4. History of restricted pericarditis
5. Sleep apnea
6. Pneumoconiosis
7. Hypothyroidism
8. Diabetes

PLAN: At this time he is being admitted. O2 supplementation, protime, TSH and blood gas will be obtained. We will consult pulmonary services for possible

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

therapeutic thoracentesis. He will be started on IV diuresis at this time. Pneumatic hose. Continue with his anticoagulation therapy. Consideration for transfusion will be considered. Stools will be monitored for occult blood.

Lynn Smith, M. D.

D: 01/04/01 1221
T: 01/04/01 1358
WJC

PMT, Inc. Job #: 4078

RECEIVED JAN 05 2001

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC: _____

Jackie Fitzwater

06/01/01

Lynn N. Smith, M.D.

S: Jackie is back in today. His wheezing has improved but his weight is starting to climb back up. He has put back on about 10-12 lbs of fluid weight. He has not had any frank PND or orthopnea. He has not had any leg cramps, palpitations or chest pain. **Past medical history** is very complicated with a history of corpulmonale with restrictive carditis. He has COPD, sleep apnea.

Jackie Fitzwater

06/01/01

Lynn N. Smith, M.D.

Page 2

EXAMINATION: He has some minimal rales at his bases. His weight is up. His BP is good at 104 but when standing it goes up to 122. He does have his 2+ pitting edema which is unchanged. He has not been using his pneumatic hose at home. His valvular click is unchanged. No new diastolic murmur. No audible S3 gallop. No wheezing on pulmonary exam at this time.

IMPRESSION:

1. Corpulmonale.
2. Restrictive paracarditis.
3. S/P valve replacement.

PLAN: 1. We will get him back on his pneumatic hose, put him back on his Zaroxolyn 5mg every other day. 2. We will monitor his weight and BP. 3. His potassium will be monitored today along with his protime and TSH.

L. Smith, M.D./ssd/D: 06-01-01/T: 06-07-01

PHONE CALL

FOR _____	DATE 6/18	TIME 12:16 A.M.
M. Nelson - female		
OF _____		
PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE <input checked="" type="checkbox"/>	438-6871	
AREA CODE	NUMBER	EXTENSION
MESSAGE Jackie Fitzwater needs Refill		
SIGNED <i>mm</i>		

WIPs FORM 4003

6/18/01
Flomax .4 #60/SK
Cardyn¹² ER #30/SK
mm

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

5/18/01

WT

256

BP

102/58

PULSE

88

CC:

Dizziness
nausea

— 122/82 P-84

100/62 P-84

90/60 P-

Jackie Fitzwater

05/18/01

Lynn N. Smith, M.D.

S: Jackie has been having some dizziness and some mild increasing shortness of breath. He has had an increased cough with light sputum production that has been clear. No fevers or chills or night sweats. He was recently hospitalized because of his cor pulmonale and his heart failure symptoms.

EXAMINATION: He is orthostatic. His weight is stable. Lungs show congestion with expiratory wheezing. No real rales. His murmur is unchanged. He has about 1-2+ pitting edema which is actually acceptable for him. His electrolytes are checked and his potassium is still low at 2.3. It is up slightly from his hospitalization.

IMPRESSION:

1. Orthostatic hypertension, secondary to diuretics.
2. Restrictive pericarditis.
3. S/P aortic valve replacement.
4. COPD.
5. Pneumoconiosis with exacerbation.
6. Hypocalcemia.

PLAN: 1. We will hold his Zaroxolyn. 2. We will increase his potassium to 20 meq 4 times a day. 3. We will put him on a taper of Prednisone dose at this time for his bronchospasm. 4. He will continue with his nebulizer therapy. 5. They will monitor his pressures over the weekend and we will recheck them next week.

L. Smith, M.D./ssd/D: 5-18-01/T: 5-23-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

S.O.B.

5/8/01

271

112/62

96

Jackie L. Fitzwater

04/19/01

Lynn N. Smith, M.D.

S: Jackie is back in today. He has been having increasing peripheral edema and some more neuropathy symptoms. Unfortunately this gentleman once again got confused on his medication and instead of adding the .1mg to his existing .25mg of his Synthroid, he has only been taking the .1mg. This gentleman had a TSH of 73 the last time and I would not be surprised if it is even higher yet since in reality he has cut his dose down instead of increasing it as we had recommended. Our records show that we added the

Jackie L. Fitzwater

04/19/01

Lynn N. Smith, M.D.

Page 2

.1mg to his .25mg dose on a regular basis.

EXAMINATION: Lungs are clear. His valve click is unchanged. He does have about 1-2+ pitting edema. His weight is actually down about another 8-10 lbs. BP is still running about 106 systolic.

IMPRESSION:

1. Hypothyroidism - not adequately treated.
2. Cor pulmonale.
3. Restrictive paracarditis s/p valve replacement.

PLAN: 1. We will get him back on the total dose of his Synthroid for now. 2. We will draw a TSH and protime. I will not make any major changes in his therapy until we try to get something done with his hypothyroidism.

L. Smith, M.D./ssd/D: 4-19-01/T: 4-25-01

PHONE CALL

FOR <u>3:00 Kathy</u>	DATE <u>5/17</u>	TIME <u>9:00</u>	P.M.
M <u>some better</u>	NAME <u>Jackie Fitzwater</u>		
PHONE <u>438-6633</u>	AREA CODE	NUMBER	EXTENSION
MESSAGE <u>Dizzy SOB - feels worse now than when he was in hospital.</u>			
SIGNED	FORM 4003		

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

3/8/01

WT

266 1/2

BP

92/46

PULSE

88

CC:

Chest
soreness

Jack Fitzwater

03/08/01

Lynn N. Smith, M.D.

S: Jackie is in today. He has been having some chest congestion and cough. He has been coughing so much that I think that it has made his chest sore. It hurts when he coughs, twists, when he lies on his right side. He has not had any shortness of breath. His weight has gone up a few pounds. His peripheral edema has been under good control.

EXAMINATION: He has some minimal chest wall tenderness on the right but his sternotomy is well healed. His lung fields are clear. Cardiac shows his valve click with no diastolic component. He has no new murmurs. He is also still in his irregular atrial fibrillation. He has only trace peripheral edema which is good for him. His weight is up to 166 lbs so obviously we cannot blame the fluid retention on that.

IMPRESSION:

1. Chest wall pain.
2. URL
3. Prosthetic valves, s/p valve replacement.
4. Known restrictive pericarditis.
5. Hypothyroidism.

Jack Fitzwater

03/08/01

Lynn N. Smith, M.D.

Page 2

PLAN: 1. We will use **Humibid LA** as a mucolytic agent and **Ceftin** 250mg bid for one week. 2. He will use some **Vioxx** for his chest wall discomfort anteriorly with some moist heat. 3. We will recheck his TSH and his BMP at this time.

L. Smith, M.D./ssd/D: 3-08-01/T: 3-13-01



VALLEY MEDICAL ASSOCIATES, INC.



Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

HC 70, Box 16 (Rt. 92)
White Sulphur Springs, WV 24986
(304) 536-1014

CLINIC NOTE

RICHARD R. DURHAM, D.O., FCCP

NAME: Jackie Fitzwater

DATE: 2-21-01

HISTORY: Mr. Fitzwater is a sixty-four year old male with rheumatic heart disease, S/P aortic valve replacement currently on Warfarin. He has a history of restrictive pericardial disease, obstructive sleep apnea, paroxysmal a-fib, type II diabetes, thyroid disease, and peripheral neuropathy. Jackie has had increased respiratory symptoms since yesterday with productive cough with some low-grade fever, no fevers or sweats. He also several days sliced his right thumb. He is not sure about the last Tetanus shot that he has had.

MEDICATIONS: Currently include Synthroid .25mg qd, KCL 10meq qd, Warfarin 7mg qd, Paxil 20mg qd, Combivent two puffs q4h, Glucotrol XL 5mg qd, Flomax .4mg bid, Proscar qd, Demadex qd, Prilosec 20mg qd.

PHYSICAL EXAMINATION: BP: 118/64, P: 92, R: 24, T: 98.2, WT: 272/2. He is generally alert, in no apparent distress. Skin: he has a large cut on his right thumb. HEENT: EOML, PERLA. NECK - no JVD, bruits, or adenopathy. HEART: Regular, S1 and S2, without murmur or gallop. LUNGS - scattered rhonchi with occasional expiratory wheeze, slightly decreased breath sound in the right base. ABDOMEN is soft, obese, non-tender, without mass, organomegaly or bruits. Bowel sounds are present in all four quadrants. EXT: trace edema in both lower extremities. NEURO: non-focal.

ASSESSMENT: He is a sixty-four year old male with a recent injury to his right thumb and probable acute bronchitis with a baseline history of rheumatic heart disease, S/P AVR, restrictive pericardial disease, obstructive sleep apnea, paroxysmal a-fib, type II diabetes, thyroid disease, peripheral neuropathy.

RECOMMENDATIONS: 1. He will be given a TD 0.5mg IM. 2. He will have a PA & Lateral chest x-ray. 3. He will have a Protime and INR. 4. We changed the dressing on the right thumb. 5. He will be given _____ 400mg qd for 7 days. 6. He will follow up in three months.

Richard R. Durham, D.O., FCCP

RRD/pab
T: 3-3-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE _____ WT _____ BP _____ PULSE _____ CC: _____

PHONE CALL			
FOR	Kathy		DATE 2/12 TIME 1:00 P.M.
M	Jackie Fitzwater		
OF			
PHONE	MOBILE	438-6633	
MESSAGE			
Sick - lost weight 24lb			
losing fluid -			
HSA - D/C Zardexin			
SIGNED		FORM 4003	

2/12/01 Wt. 253 1/2 BP 96/60 P 80 cc Fluid
nausea

JACKIE FITZWATER 02-12-01 LYNN N. SMITH, MD

- S- Jackie comes in today. He has actually lost about 8 pounds in weight and he was concerned because on his scales he had lost quite a bit more. His peripheral edema has improved. He has no real orthostatic symptoms. But if he gets up in a hurry, he does note some mild dizziness. He has been on replacement with his new SYNTHROID for only about 2 weeks.
- O- BP is about 96/60. He is not tachycardiac. He has no periorbital puffiness. He has only trace peripheral edema at this time. He also had a bout of gastroenteritis recently with some nausea and diarrhea. He had multiple episodes of vomiting mostly bilious type of material. He is s/p cholecystectomy. He has not had any blood or melena. He has no abdominal tenderness or distention. Cardiac exam shows his click, which is unchanged. His lungs are clear.
- A-
1. Post valvular replacement.
 2. Hx of restrictive pericarditis
 3. Hypothyroidism
 4. Nausea and vomiting with probably bile reflux
- P-
1. He will go on CARAFATE 1 gram tid 30 minutes a.c.
 2. We have given him some PHENERGAN suppositories prn nausea.
 3. He will eliminate all diuretics at this time for the next 48 hours then he will start back on just DEMADDEX qd. He will stay off the other.
 4. He is due for a recheck on his thyroid in approximately one month.

LNS:pb

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

2/2/01 v. called advised A Synthroid 40 .25 gr
Synthroid .1 #30 /3RF called to .1 gr
Terminal - NAME BRAND 10V BH 1 month

2-7-01 Nasuel NS - 1 - 3RF
Terminal 20

2/8/01 WT 262 BP 116/58 P 92 CC followup

JACKIE FITZWATER

02-08-01 LYNN SMITH, M.D.

S- Jackie was found to be significantly hypothyroid with his TSH level up to 66. I think this does explain some of his fluid retention, etc. He was started on a high dose of SYNTHROID at this time. We have put him on a fairly steep dose and we are going to recheck him in about a month. He is already feeling better. He has lost about 8-9 pounds. He is much less puffy as far as his periorbital findings are concerned. He actually says that he feels quite well. He is due for a recheck on his Protine today.

O- No real change in his physical exam. Lungs are clear. Peripheral edema has improved.

- A- 1. Hypothyroidism
2. Hx of restrictive pericarditis
3. S/p prosthetic valve

- P- 1. He will be rechecked in about a month on his new thyroid dose.
2. We will monitor his Protine as before.

LNS:pb

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

*2/1/01**273**120/60**80**V. up*

JACKIE FITZWATER

02-01-01 LYNN SMITH, M.D.

S- Jackie is back in today. His evaluation at Charlottesville basically they did not redo the cath at this time. They have him on medical management and feel that is probably adequate. He has had about a 6-8 pound weight gain since he was last in the office. Although he says that he as done very well for the last several days. He denies any SOB, PND or orthopnea. He says that he has been feeling better than usual and he has been driving.

O- He does have a lot of periorbital puffiness, which he normally doesn't have. His weight is up about 6-8 pounds. Lung fields are clear. There are no rales. There are no new murmurs, rubs or gallops. He does have 2+ edema, which is unchanged.

- A- 1. Restricted pericarditis
2. Cor Pulmonale
2. Hypothyroidism with questionable thyroid status

- P- 1. We will repeat his Protime, BMP and I want to get a TSH level.
2. He will use his ZAROXOLYN 2.5 every other day for 3 doses to keep her fluids under control.
3. We will contact him as soon as we have his lab results. LNS:pb

PHONE CALL			
FOR	<i>Nurse</i>	DATE	<i>2/1/01</i>
M.	<i>Nelson</i>	TIME	<i>10:19</i> AM: P.M.
OF	<i>1 Criminal Drug</i>		
PHONE	<i>438-6841</i>		
MESSAGE	<i>At Jackie Fitzwater</i>		
	<i>Paxil 24 #30 SRT.</i>		
SIGNED			

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE 1/12/01 WT 264 1/2 BP 92/62 PULSE 96 CC: Hoap
F 10

JACIE FITZWATER 01-12-01 LYNN N. SMITH, MD

- S- Mr. Fitzwater was recently hospitalized with a symptomatic pleural effusion post pericardial stripping. He has done better at home. We took about 1400 cc of fluid off and also put him back on his diuretics. We will have him re-evaluated at Charlottesville with a right heart cath to determine if his pulmonary hypertension is the reason for his swelling now or whether he still has evidence of his restrictive pericarditis.
- O- There is some dullness at the right base consistent with his effusion. He has no new murmurs. His valve click is unchanged. He is down to 1+ edema, which is improved for him. His blood pressure is running a little low at about 96/70.

- A- 1. Hx of restrictive pericarditis
2. S/P aortic valve replacement.
3. COPD with Cor Pulmonale
4. Sleep apnea.

- P- 1. We will leave his medicines the same for now.
2. We will draw a Protime and CBC.
3. He is due to see Cardiology services within the next week for re-evaluation.

LNS/pb

PHONE CALL			
FOR <u>Nurse</u>	DATE <u>1-15</u>	TIME <u>12/12</u>	<u>P.M.</u>
OF <u>Jackie Fitzwater</u>			
PHONE <u>Demond - HCP - 438 1663</u>			
PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE <input type="checkbox"/>			
MESSAGE <u>Needs Fluid Med</u>			
<u>Demond called to T...</u>			
<u>Also has Appt</u>			
<u>ben made in Charlotte</u>			
SIGNED <u>[Signature]</u>			

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE 1-4-01 WT 266 BP 100/54 PULSE 124 CC: 5/P UVA —

JACKIE FITZWATER 01-04-01 LYNN N. SMITH, MD

S- Jackie is being admitted to the hospital from the office today with what appears to be a marked occurrence of his peripheral edema. He has a large right pleural effusion with O2 sat in the 85% range and a Hgb of 8. He has recently had a pericardial stripping procedure for his restrictive pericarditis and he will be re-evaluated at this time and symptomatically treated. He is being admitted.

LNS/pb

PHONE CALL			
FOR <u>Nurse</u>	DATE <u>1-9</u>	TIME <u>9:57</u>	AM/PM
M			
OF <u>Alma - HCP</u>			
PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE	645-1706		
AREA CODE	NUMBER	EXTENSION	
MESSAGE <u>Re: Jackie Fitzwater</u>			
<u>discharged yesterday for time seeing</u>			
<u>not?</u>			
SIGNED <u>[Signature]</u>			

FORM 4003

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

RECEIVED MAY 09 2000**X-Ray Requisition & Report**

Fitzwater
JACK

X-Ray No. 2958Date 5 10 00Age 42 5 36Referring Physician L SmithExamination Desired CXRClinical Information CHF**Radiology Report:****JACK FITZWATER****CHEST, TWO VIEWS:**

The frontal and lateral views are underpenetrated.

There has been a previous sternotomy. Moderate cardiomegaly is seen. There is an increase in the markings suggesting COPD. No edema or effusion is seen.

IMPRESSION: CARDIOMEGALY.
Signed by Heather Rose, M.D.HR/mek
T: 5-04-00

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

Fitzwater, Jackie

X-Ray No. 2958

Date 3-10-00

Age 4-25-36

Referring Physician L. Smith

Examination Desired CXR

Clinical Information T. edema - SOB

Radiology Report:**JACKIE FITZWATER****CHEST, TWO VIEWS:**

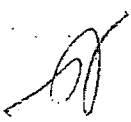
Gross cardiomegaly. Status post thoracotomy. No evidence for focal infiltrate. There is a right pleural effusion with venous congestion. Some pleural thickening suggested.

IMPRESSION:

1. RIGHT PLEURAL EFFUSION.
2. VENOUS CONGESTION.
3. FINDINGS CONSISTENT WITH SOME DEGREE OF CONGESTIVE HEART FAILURE.

NOTE - ON A FILM OF 9/99, THERE ALSO WAS A RIGHT PLEURAL EFFUSION.

T: 3-13-00/DCM/crw

 Signed by David C. Maki, D.O.

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 63 SEX: M
ACCT: D00098129184 LOC: D.PCU 1
EXAM DATE: 01/15/2000 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000155045 PORTABLE CHEST AP/PA ONLY

PORTABLE CHEST

CLINICAL HISTORY: SYNCOPES

There has been a previous sternotomy. Mild to moderate cardiomegaly is seen. There is no superimposed edema or consolidation. Chronic blunting of the right costophrenic angle is seen.

IMPRESSION: CARDIOMEGALY.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT, Inc. Job# 7423

** REPORT SIGNATURE ON FILE 01/15/2000 **
REPORTED AND SIGNED BY: Heather Rose M.D.

CC: Lynn Smith, M.D.

Dictated Date/Time: 01/15/2000 (1104)

Technologist: Ruth E Craft RT(R) (M)

Transcribed Date/Time: 01/15/2000 (1324)

Transcriptionist: DMRWJC

Printed Date/Time: 01/15/2000 (1508) BATCH NO: 3284

PAGE 1

Lynn Smith, M.D.

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

11-29-00

258

Relief 64

For (R) lower leg

Full holter monitor results

Jackie L. Fitzwater

11/29/00

Lynn N. Smith, M.D.

S: Jackie is back in. He is down 20 lbs since he has been using the Zaroxolyn in combination. He has not had any dizziness. Shortness of breath is improved. His new problems include some swelling and pain in his right leg. He has also noted an increase in erythema over the last several days. He has not had any chest pain or palpitations. His Halter monitor, however, did show evidence of frequent episodes of atrial fib and flutter with heart rates in the 130 to 150 range. He does have a baseline rhythm of sinus rhythm with these frequent episodes. He has been fully anticoagulated on his Coumadin because of his prostatic valve.

Past medical history is significant for valvular heart disease, a restrictive pericardial disease postoperatively. He has a history of diabetes and pulmonary hypertension. His ROS shows that he has actually been feeling better. He has had less shortness of breath. No PND or orthopnea. He has not had any orthostatic complaints such as dizziness. He has had a good appetite. He has had no GI symptoms. He has had some pain and discomfort in the right leg and still continues to have swelling in that region.

O: His blood pressure is down a little at this time at 96/70. His pulse is regular at this time in the 80's. He has clear lung fields. He has his valve click. No new murmurs. No gallops. He is still obese. His right leg shows increased erythema and heat involving the anterior portion of his right leg. He always has some chronic discoloration here in the past but this is significantly increased and it also with an increase in tenderness at this time. He has about 1+ edema. His weight is down approximately 20 lbs.

IMPRESSION:

1. Restricted pericardial disease with corpulmonale.
2. Probable early cellulitis, right lower leg.
3. Valvular heart disease s/p aortic valve replacement.
4. Atrial fib flutter, currently not adequately controlled on Rhysmol.

PLAN: 1. D/C the ~~Rhysmol~~ since he is still having frequent breakthroughs. We are going to put him on **Cardizem CD** 120mg qd but wait 2-3 days off of his diuretics until his blood pressure comes up a little bit. He is going to be started on **Keflex** 500mg 4 X per day with warm soaks to the right leg. 2. We will also contact his cardiologist to determine if further f/u at UVa is necessary at this time.

L. Smith, M.D./ssd/D: 11-29-00/T: 12-02-00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE 11-14-00 WT 278 BP 110/68 PULSE 68 CC: pt stated he fell
2 wks ago Booto

JACKIE FITZWATER 11-14-00 LYNN N. SMITH, MD

S- Jackie comes in today after 2 weeks ago, having sustained a frank syncopal episode. He evidently had gone to the bathroom and came back out and was sitting at the dining room table. The next thing he knew he was in the floor. He had actually hit his head and had a little bit of a nose bleed from that. Evidently an ambulance squad was called. They came and did EKG, blood pressure check, all of which was normal. He had no warning whatsoever of this. He remembers sitting down and the next thing that he remembers is waking up in the floor. He doesn't feel that he was out for very long. It was not witnessed. By the time somebody came in, he had already had the fall. He did not have any significant palpitations. He had had no dizziness, no weakness, no symptoms whatsoever prior to this. He has had a couple of episodes of dizziness in the past, which we thought was orthostatic and we have been able to reproduce with his blood pressure changes. He has put on quite a bit of weight and some increased fluid as of late. He has the known prosthetic valve.

PMH: He has hx of sleep apnea, known hx of coronary disease, valvular heart disease s/p valvular replacement, diabetes, and cor pulmonale with restrictive pericarditis.

O- His weight is up to 278. Lung fields are clear. He has minimal rales at the right. His valve click is normal. I don't hear any diastolic murmur, no new other murmurs. He has about 1+ pitting edema. BP is stable without orthostatic change at this time.

- A- 1. Syncope questionable cardiac arrhythmia
2. Hx of valvular heart disease
3. Restricted pericarditis

- P- 1. We are going to put a Holter Monitor on his at this time.
2. We will recheck his BMP, K+ and Mg level.
3. We will bring him back in after these have been performed.
4. I am management pending this evaluation.

LNS/pb

PHONE CALL	
FOR <u>Kathy</u>	DATE <u>11-17</u> TIME <u>11:55</u> A.M. P.M.
M. <u>Jackie Fitzwater</u>	
OF <u>Jackie Fitzwater</u>	PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE <input type="checkbox"/>
PHONE <u>438-6633</u>	AREA CODE <u>438</u> NUMBER <u>6633</u> EXTENSION <u></u>
MESSAGE <u>Lots of fluid retention</u> <u>So B</u> <u>Start Zosyn 2.5 x 23</u>	
SIGNATURE <u></u>	

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

9/22/00

254 1/2

P-96

CC: syncope

140/82

P-96

Dr. Karis - 11-14-00

124/82

P-94

Cardiac Rehab - thing with

112/78

P-92

Dietician - Lorraine VA

9/29/00

WT 261

BP 110/60

P 100

CC Vp

100/62 88

100/70 88

118/70 88

3 mrs 100/62 100

Jackie L. Fitzwater

9/29/00

L. N. Smith, M.D.

S: Jackie is here for follow up. His weight has come back up about a total from 254 to 261. He has a little of his peripheral edema back. He, overall, is feeling much better. His dizziness is improved. He still has a lot of pain in his shins. He complains of this deep, aching pain in his bones. This is not a peripheral neuropathy, which he said he can separate between the two. If he ever puts any pressure on it, gets down on his legs, he has tremendous pain in the shin region. He is not having any shortness of breath. He is actually feeling much better. His spirits are much better at this time.

O: Physical examination: He is no longer orthostatic. Lung fields are clear. He has about 1+ edema bilaterally and still marked tenderness along the shins bilaterally to palpation. No organomegaly. Cardiac shows his valve click, which is unchanged. He has no new diastolic murmur.

ROS: Appetite is good at this time. His activity level has improved. He is having no nausea, vomiting, diarrhea, nor is he having any significant shortness of breath.

A: 1. S/P valve replacement with restricted pericarditis. 2. Leg pain, questionable etiology. 3. Diabetes with adequate control - please not his HgbA1C is in the 6 range. 4. Orthostatic hypotension - resolved.

P: 1. We are going to continue with his current medical management.
2. Pro time is drawn today.
3. We will get a bone scan to evaluate his leg for his leg pain, especially the tibial regions.
4. He will continue with his exercise program.
5. We are still waiting for both a dermatology consult and for his dietitian consult.

LNS/dll

D: 9/29/00

T: 10/9/00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC:

Jackie L. Fitzwater

9/22/00

L. N. Smith, M.D.

S: Jackie comes back in today. He is doing better. His weight has come up about six pounds and his BP is improved. He is now slightly orthostatic with systolics dropping from 140 to 112, but he is not very symptomatic. He is also not having any shortness of breath. His labs show there was no real change in his Creatinine of 2.3, but BUN was elevated in the 60's consistent with his pre-renal change as well as his underlying renal deficiency.

O: Physical examination: He still doesn't have much in the way of peripheral edema. Trace at best. Lung fields are clear. Cardiac is unchanged.

A: 1. Restricted pericarditis. 2. COPD. 3. Renal insufficiency. 4. Diabetes mellitus - HgbA1C is well controlled at 5.7.

P: 1. I've had a long discussion with he and his wife today. I tried to explain to them the importance of getting his weight down, which I think will have a major improvement and impact on both his diabetic management, his exercise tolerance, and his cardiovascular situation.

2. At this time, we are going to institute the following changes. He will hold his diuretics until tomorrow then start back on **Demodex** and **Spironolactone**, but do not take any **Zaroxolyn**.

3. We will do formal diabetic teaching again with a diabetic class with dietary instructions for both he and his wife.

4. We will start him in a cardiac rehab program to see if we can't get this gentleman a little better tuned into exercise.

LNS/dll

D: 9/22/00

T: 10/4/00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC:

9-20-00	WT	248	BP	104/66	P	96	CC
—		118/74		P-96			
4		94/66		P-96			
—		72/58		P-92			

JACKIE FITZWATER 09-20-00 LYNN N. SMITH, MD

S- Jackie comes in with c/o dizziness and lightheadedness over the last week. He says that when he gets up he starts to stagger. He has never really passed out. But he says that he has been close to that. He continues to use the maximum of diuretic therapy despite our recommendations to monitor his fluid. He is also using the pramoxine hose, which seem to be working well for him. He has not had any CP and no change in his appetite. In fact, his sugars have been up a little bit but according to his wife he eats almost completely non-stop from the time he comes home in the evenings to the time he goes to bed. He eats things like potato chips, candy bars on occasions.

O- His BP is extremely orthostatic with BP's of about 110 which drop to 75 when he stands. He does get symptomatic. Lung fields are clear. Cardiac exam shows no new murmurs or gallops. He is obese abdominally but I don't feel any tenderness. He has no significant peripheral edema. He has chronic rash on his arms, which is very excoriated. The etiology at this time is unclear, but I think it does warrant further evaluation, especially with his diabetic condition.

- A-
1. Orthostatic hypotension
 2. Restrictive pericarditis
 3. DM type II
 4. Hx of renal insufficiency
 5. COPD

- P-
1. We will have him hold all diuretic at this time.
 2. We will get a metabolic panel drawn today and a HgA1c.
 3. I have asked him to stay at strict rest at home, this includes virtually no ambulation.
 4. He will increase his po fluid intake.
 5. RTO in 48 hours or sooner if his symptoms show any signs of worsening. We will monitor his pressures at that time.

LNS/pb

VALLEY MEDICAL ASSOCIATES, INC.

Flt 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

9/1/00

253

120/78 - P-80

Sick

Laying

120/78 - P-76

Nauseated

Sitting

120/80 - P-80

dizzy

Standing

118/72 - P-76

B12 Injection given per LNS - SA

Jackie Fitzwater

9/1/00

Lynn Smith, M.D.

S: Mr. Fitzwater is actually doing fairly well. He had some dizziness actually the last time he was here and has what appeared to be some positional dizziness. He states that has actually gotten better. He has a little bit of dizziness when he gets up quickly; tends to stagger a little bit to the right. His overall peripheral edema has been good; appetite has been good; no chest pain. He has not had any significant ear symptoms as of late that did occur a week or two ago.

O: VITALS: His blood pressure is stable; no orthostatic change when we sit him up; no positional change.

ENT: Ears - clear.

HEAD: No vertigo with any type of head movement.

LUNGS: Clear.

EXTREMITIES: Legs are actually in pretty good shape for him; trace peripheral edema at best.

SKIN: No evidence of any new skin break downs or lesions.

IMPRESSION:

1. Restrictive pericarditis
2. Diabetes - known peripheral neuropathy
3. Hypertension - currently on adequate therapy

PLAN: 1. We are going to continue with his current medications. I see no change in therapy at this time. His vertigo has cleared spontaneously, and I see no evidence of any significant orthostatic change that would require change in his overall medications.

L.N. Smith, M.D./mek/D: 9-01-00/T: 9-07-00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie FitzwaterDATE 8/28/00 WT 252 BP 120/84 PULSE 96 CC: P/O- 126/86 P - 967 116/76 P - 1001 108/68 P - 100

Jackie Fitzwater

8/28/00

Lynn Smith, M.D.

S: Mr. Fitzwater looks a lot better. His weight is down 15 pounds. He is beginning to get a little orthostatic symptoms; not feeling well. His electrolytes are good but his creatinine was up to 2.4. He is a little orthostatic today, dropping from 126 down to 106 and a little dizziness with it, but not bad.

O: CARDIAC: Valve clicks are unchanged; no diastolic murmur.

LUNGS: Clear.

EXTREMITIES: No peripheral edema.

IMPRESSION:

1. Restrictive pericarditis
2. Cor pulmonale
3. Orthostatic hypertension - secondary to diuretics
4. Diabetes

Jackie Fitzwater

8/28/00

Lynn Smith, M.D.

Page 2

PLAN: 1. We are going to cut down his Zaroxolyn to 2.5 q.o.d. 2. Will monitor his weight. 3. We are going to bring him back in at the end of the week to recheck his creatinine and electrolytes. 4. He is going to hopefully feel a little better from an orthostatic standpoint. L.N. Smith, M.D./mek/D: 8-28-00/T: 8-31-00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

6/9/00

259

110/80

88

F14

JACKIE FITZWATER

6/9/00

Lynn N. Smith, M.D.

S: Jackie is back in for his follow-up. He took his Prednisone and actually did very well when he was on the steroids as far as his ambulation and his shortness of breath is concerned. His weight is down 5 pounds. He has been able to walk more. We still haven't gotten quite the pneumatic hose that we have wanted. The UMWA is requesting that some further forms be filled out. I do feel with his chronic lymphedema, his restrictive pericarditis, his venous insufficiency, that all of these are major factors and would justify the use of these pneumatic stockings at home to try to minimize his recurrent edema. He has had no chest pain. His cough has been better and he has had very little wheezing.

O: On exam today he has a little wheezing in his left lower base that clears. His weight is down 5 pounds. He still has his chronic edema but there are no areas that are open or draining at this time.

A:

1. Status-post valve replacement.
1. COPD.
1. Restrictive pericarditis with right-sided failure.

JACKIE FITZWATER

PAGE 2

PLAN: We are going to continue with his current medical regimen, but we are going to start him on Azmacort 4 puffs twice a day to try to help with his breathing since he did so well with the steroids. He is going to continue with his walking weight-reduction program. His protime is drawn today and his B-12 shot is given.

T: 6/12/00 agz

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

5/19/00 264

118/72

88

✓ leg

Jack Fitzwater

5/19/00

L. N. Smith, M.D.

S: Jack is in today because of increased swelling in his legs. He has been on them a whole lot more as of lately. He has some redness, swelling, and drainage from the left anterior tibial region. He has had some minimal discomfort with it as well. No shortness of breath.

Jack Fitzwater

5/19/00

L. N. Smith, M.D.

Continued

O: Physical examination: Wt: down about 3-4 pounds since we changed his diuretic. Lungs: Clear. He has no real wheezing at this time. He sounds much better than before. He has 1-2+ pitting edema bilaterally. There is some early redness, tenderness, and some mild drainage from the left leg. This is fairly early on.

A: 1. Cor pulmonale secondary restrictive cardiac disease. 2. Cellulitis left leg.

P: 1. We are going to put him on Keflex 250 mg qid.

2. Moist compresses.

3. I've asked him to stay off of it, keep his feet elevated, and continue with his diuretic therapy. He is to contact us the first of the week for follow up.

LNS/dll

D: 5/19/00

T: 5/24/00

WHILE YOU WERE AWAY

FOR <i>Nurse</i>	DATE <i>5-22</i>	TIME <i>4:44</i> P.M.
M <i>Jackie Fitzwater</i>		
OF <i>430-6633</i>	PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE	
MESSAGE <i>Feeling better!</i>	SIGNED <i>[Signature]</i>	

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

FORM 4002

PAT

DATE

WHILE YOU WERE AWAY

FOR	<i>Nurse</i>	DATE	<i>4-24</i>	TIME	<i>10:21 A.M.</i>
FROM	<i>Relson - Terminal Drug</i>				
OF	<i>RE: Jackie Fitzwater</i>				
PHONE	<input type="checkbox"/> FAX	<input type="checkbox"/> MOBILE			
MESSAGE	AREA CODE	NUMBER	EXTENSION		
<i>Insurance won't pay for procedure</i>		<i>438-6871</i>			
<i>But will pay for Dialysis - Can we</i>					
<i>be charged? W OK</i>					
SIGNED					

FORM 4002

5/1/00 Wt - 267 VSP 106/80 P 100 Cc V(R) leg

JACKIE L. FITZWATER 05-01-00 LYNN SMITH, M.D. *JD*

S- Jackie noted some increase in swelling and some shortness of breath over the last couple of days. We treated an upper respiratory infection which did clear. He had a lot of pain in his right leg consistent with some neuropathic pain. This occurred on the outer aspect of his right calf for about 48 hours and is gone today. He actually says he feels pretty good. We have treated his infection and that is improved. He still has a little dyspnea on exertion. His weight has been up a little bit.

O- On exam today he has some minimal rales of his bases. His murmur is unchanged. His valve click is unchanged. He does have about 2+ edema bilaterally. I don't see anything on the leg and I can't palpate any tenderness in the site that was tender. Chest x-ray does show some mild volume overload but no evidence of effusions.

A- 1. Cor pulmonale with history of congestive heart failure.
2. Neuropathic pain.

P- 1. We are going to get his basic metabolic panel at this time and his protime.
2. I have increased his **demadex** to 100 t.i.d. just for the next three days.
3. Continue with his other medications.
4. Will followup on Thursday by phone call.

T: 5/8/00 LNS: wc

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE WT BP PULSE CC:

WHILE YOU WERE AWAY

DATE <u>3-2</u> TIME <u>11:24 AM</u>		PHONE <u>438-6871</u>	
NAME <u>Nelson</u>		TERMINAL DISEASE	
MESSAGE <u>Jackie Fitzwater</u>		SIGNED <u>ml</u>	
AREA CODE		NUMBER	
EXTENSION		WILL CALL AGAIN	
WANTS TO SEE YOU		FORM 4002	

3/2/00 called to
terminal Council
by gnd #30 PDX2
per WSLER

3/10/00. WT. 269 1/2 BP - 118/68 P 84 cc. edema

Jackie Fitzwater

3/10/00

L. N. Smith, M.D.

S: Jackie is back in today. He is having increased swelling. He has put on about six pounds in the last week. A little more shortness of breath. He has had no chest pain or cough or sputum production.

Past Medical History: Positive for restrictive pericardial disease. He had a valve replaced. History of cor pulmonale and pulmonary hypertension.

O: Physical examination: He is not in any respiratory distress at rest. Vital signs are stable. He is not tachycardic. Lung fields show some minimal rales at the right base. He always has a protuberant abdomen and I can't tell whether there is any real acidic fluid present. It has never been in the past. He does have increasing edema 2+ now, but there is no weeping, which he has had when he has been at his worst.

A: 1. Increasing cor pulmonale with right-sided failure. 2. Valvular heart disease. 3. Restrictive pericardial disease.

P: 1. We are going to switch him to Demodex 100 mg bid.

2. DC the Lasix.

3. His BMP and pro time is drawn today.

4. I've asked him to follow up the first of the week to let us know if his weight is going down and to actively take his weight everyday in the morning, which I have requested him to do, but I don't think he has done on a frequent basis.

LNS/dll

D: 3/10/00

T: 3/11/00

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE WT BP PULSE CC:

2/21/00 - Albuterol 50 mg - #90 - 3 R
Paxil 20 mg - qd 30 3 R
Albuterol 24 - 5 mg - qd 30 3 R
Summit 24 per Dr Smith
2/24/00 Wt 260 B/P 120/70 P-84 2wk F/u
B12 injection given per CNS-SA

Jackie Fitzwater

2-24-2000

L. N. Smith, M.D.

S: Jackie seems to be doing pretty well. He has put a few pounds of weight back on due to some fluid but he is feeling well, eating well. He has had an active sinus infection. He has had a couple of nosebleeds recently and some greenish type drainage. With his CPAP, I think that is also a contributing factor. He has been using the Ocean Spray but only about a 2-3 x a day basis.

O: On exam he has a little tenderness in the left mastoid region. Nose is dry with some crusty purulent material.

A: IMPRESSION:

1. Sinusitis.
2. Valvular heart disease.
3. Cardiomyopathy, restrictive.

P: We are going to put him on Augmentin 875 mg bid. He is going to use his Ocean Spray more frequently. He is going to continue with his other medicines for now B-12 shot is given today. Follow-up for his prostate in about three weeks and repeat evaluation in 2-3 months. T: 2-25-00/crw

WHILE YOU WERE AWAY

FOR <i>Nurse</i>	DATE <i>3-1</i>	TIME <i>9:44</i> A.M.
M		
OF <i>Jackie Fitzwater</i>		
PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE <input type="checkbox"/>	AREA CODE <i>438</i>	NUMBER <i>6633</i> EXTENSION <i>01</i>
MESSAGE <i>Summit ?</i>		
SIGNED <i>Symptoid (15) had been taking 12 (12 called #3015) per</i>		
		<input type="checkbox"/> PHONE <input type="checkbox"/> RETURNED YOUR CALL <input type="checkbox"/> PLEASE CALL <input type="checkbox"/> WE'LL CALL AGAIN <input type="checkbox"/> CAME TO SEE YOU <input type="checkbox"/> WANTS TO SEE YOU

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE WT BP PULSE CC: 2 wk Flt
2/10/00 253 110/64 80

Heumhatts & Co. Rec. / CHA

Jackie L. Fitzwater

2/10/00

L. N. Smith, M.D.

S: Jackie seems to be doing well. His weight is stabilized. He is still having terrible pain in that right leg with his neuropathy. He has a burning pain. He seems to be having some mild colonic problems where it tends to involuntarily jump on him. He said it doesn't hurt when it does that, it just sort of jumps. He has not had any significant change in his swelling. There has been no drainage, heat, or redness to the leg. He says he has not felt this good in a long time. He is exercising, walking, eating well. No PND, shortness of breath, or palpitations.

Past medical history is significant for peripheral neuropathy, diabetes, renal insufficiency, restrictive pericardial disease, and S/P valve replacement.

O: Physical examination: Lungs: Clear. Valve click is unremarkable and unchanged. His leg is not tense. There is minimal swelling, but it looks very good for him and I have no abnormal reflexes or any changes otherwise. His gait is good. I see no evidence of any vascular change in the lower extremity.

A: 1. Peripheral neuropathy postinflammatory. 2. Diabetes mellitus. 3. Restrictive pericardial disease.

P: 1. We will get a metabolic panel. We will also get electrolytes, including a mag level. Pro time is monitored today as well.

2. We've increased his Neurontin to 300 mg qid for his peripheral neuropathy symptoms.

Jackie L. Fitzwater

2/10/00

L. N. Smith, M.D.

Continued

3. I've given him some Flomax. He has run out of that. He has been taking it for his prostate and he has noticed some increase in nocturia. He is due to see his urologist tomorrow.

4. We will follow him up in two weeks.

LNS/dll

D: 2/10/00

T: 2/15/00

Peter J. Edgerton, M.D., F.A.C.S.

Adult & Pediatric Urology
WVVA Healthcare Alliance

Alleghany Highlands Medical Center at Alleghany Regional Hospital
Low Moor VA

FITZWATER, JACKIE L.

January 7, 2000

Patient is a 63-year-old with multiple medical problems including increasing prostatism.

AUA SYMPTOM SCORE: 31.

ALLERGIES: Negative.

ETOH: Negative.

CIGARETTES: 40-year history.

RECREATIONAL DRUGS: Negative.

MEDICATIONS: Synthroid .15mg q.d.; K-Dur 10meq q.d.; Lasix 40mg b.i.d.; Coumadin 7mg q.d.; Paxil 20mg q.d.; Combivent inhaler; Nasaril nasal spray; Rythmol 115mg b.i.d.; Fibercon q.d.; Glucotrol XL q.d.; Prevasade 15mg q.d.; Celebrex 100mg b.i.d.; Zaloxolyn 5mg q.d.

PMH: Aortic valve replacement; colcystectomy; hyperthyroid; carpal tunnel syndrome; circumcision; diabetes; hypertension; peripheral neuropathy; chronic lung disease; sleep apnea.

ROS: Negative except for above.

URINE ANALYSIS: Specific gravity of 1025, pH of 6, trace of protein; otherwise negative.

PHYSICAL EXAM: Well-developed, well-nourished obese male in no acute distress.

HEENT: Head is normocephalic. Eyes are clear. Throat is clear. There are dentures. Neck is supple, w/o masses. No carotid bruits.

CARDIAC: 2/6 systolic ejection murmur along with a click.

LUNGS: Scattered rales.

BACK: No CVA tenderness.

ABDOMEN: Obese. Bowel sounds positive. There are surgical scars.

GENITALIA: Normal male. He has extra skin, due to his obesity, even though he has been circumcised. Both testicles are descended. No appreciable hernias.

RECTAL EXAM: Prostate is 4+, normal contour, consistency and mobility; approx. 25gm in size. Stool is heme+.

(Continued)

Peter J. Edgerton, M.D., F.A.C.S.

Adult & Pediatric Urology
WVVA Healthcare Alliance
Alleghany Highlands Medical Center at Alleghany Regional Hospital
Low Moor VA

FITZWATER, JACKIE L.

January 7, 2000

Cont.

EXTREMITIES: 4+ edema.

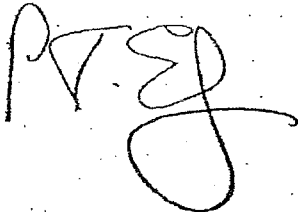
NEUROLOGIC: Oriented x three.

RESIDUAL BY ULTRASOUND: Approximately 165cc.

IMPRESSION: 1. BPH.

2. Heme+ stool. - *AND colonoscopy + polyps removed by Dr. Gandy*

PLAN: Trial of Proscar and Flomax and to address the heme+ stool when he comes back next to visit.



Peter J. Edgerton, M.D.

PJE/sd

d: 01/07/00

t: 01/10/00

cc: Dr. Lynn Smith

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE WT BP PULSE CC:

Jackie L. Fitzwater

1/6/00

 L. N. Smith, M.D.

S: Jackie is back in for his follow up and he is still having a lot of problems with his feet. The Celebrex didn't seem to help very much. Actually I think his history is really compatible with gout. His right toe at times flares up, gets very hot and painful to where he can't wear his shoes. His uric acid level was 14 when we did check it. He has been complaining some of the neuropathic symptoms, but what he is really complaining about is more arthritic. It hurts worse to walk on it. It gets better when he gets it hot, soaks it in the tub, etc. His breathing has been pretty good. Weight has been fairly stable. It is actually down about five pounds.

Past Medical History: Significant for his valvular heart disease with restrictive pericardial disease. He has a history of COPD. Osteoarthritis history.

O: Physical examination: BP is good. Lung fields are clear. Cardiac shows a valve click. He still has quite a bit of irregularity, but the EKG showed it to be multiple PAC's. He has about 1+ edema. His feet show significant tenderness in the metatarsal heads, especially in the left foot. I don't feel any heat or warmth, but they are extremely tender.

A: 1. Arthritis, possible gout versus osteo. 2. Valvular heart disease, S/P valve replacement. 3. Hypothyroidism.

P: 1. We will get his labs including TSH, pro time, and PSA level because of some urinary hesitancy symptoms and known BPH. It is over a year since that has been checked.

2. We will start him on Prednisone 20 mg in a taper.

3. I will bring him back in about 10 days to go over these results and determine if we are going to need something to try to treat him for acute and chronic gout problems.

L. N. Smith, M.D./dll

D: 1/6/00

T: 1/13/00

Charleston Area Medical Center
 Department of Medical Imaging
 General Hospital Phone : (304) 388 - 6044
 Memorial Hospital Phone : (304) 388 - 9225
 Womens and Childrens Phone : (304) 388 - 2411
 Womens Comp Care Phone : (304) 388 - 2860
 Imaging Center Phone : (304) 388 - 1660

PATIENT DIAGNOSTIC REPORT

Verified

PATIENT NAME : FITZWATER, JACKIE

MRN:

ACCOUNT :

ADMISSION DATE

LYNN N. SMITH, M.D.

10773439

1231570308

11/28/2007

ROUTE 2 BOX 171

BIRTH DATE

LOCATION

SEX

LEWISBURG, WV 24901

4/25/1936

G717 02

M

ADMITTING PHYSICIAN : KAMRAN M. MANZOOR

PRIMARY CARE PHYSICIAN : LYNN N. SMITH, M.D.

REQUESTING PHYSICIAN : KENNETH C. ADKINS

ORDER ID

ORDER DATE

REQUESTING SERVICE

DOS: 11/27/2007 23:11:18

4449882

11/27/2007

GED

REASON: ER-T2, S/P FALL, PAIN

EXAMS: CHEST 2V XR

PATIENT: FITZWATER, JACKIE L

ORDER NUMBER: 4449882

CHEST:

HISTORY: Patient fell with pain.

A two view supine study is compared to 05/30/2007. There is evidence of previous sternotomy. There is a battery pack over the anterior left chest wall. There is cardiac enlargement. There is blunting of the right costophrenic angle consistent with an old pleuritis. The lungs are clear. There is a right sided central line present.

IMPRESSION:

Chronic thoracic findings.

D: 11/28/2007 08:15 Johnsey L. Leef Jr, MD

T: 11/28/2007 08:21:48 AM hky

Job: 9341739

DICTATED BY: JOHNSEY L. JR LEEF, MD

VERIFIED BY: JOHNSEY L. JR LEEF, MD

VERIFIED ON: 2007/11/28 09:00:11.00

TRANSCRIBED: ESCRIPTION 11/28/2007 08:22

RESULT ID / ADDENDUM: 352871540

PATIENT NAME: FITZWATER, JACKIE

Charleston Area Medical Center
 Department of Medical Imaging
 General Hospital Phone: (304) 388 - 6044
 Memorial Hospital Phone: (304) 388 - 9225
 Womens and Childrens Phone: (304) 388 - 2411
 Womens Comp Care Phone: (304) 388 - 2860
 Imaging Center Phone: (304) 388 - 1660

PATIENT DIAGNOSTIC REPORT

Verified

PATIENT NAME : FITZWATER, JACKIE

LYNN N. SMITH, M.D.

ROUTE 2 BOX 171

LEWISBURG, WV 24901

MRN:

10773439

ACCOUNT:

1231570308

ADMISSION DATE

11/28/2007

BIRTHDATE

4/25/1936

LOCATION

G717 02

SEX

M

ADMITTING PHYSICIAN: KAMRAN M. MANZOOR

PRIMARY CARE PHYSICIAN: LYNN N. SMITH, M.D.

REQUESTING PHYSICIAN: VENKATA R. MONINGI

ORDER ID

4452436

ORDER DATE

11/29/2007

REQUESTING SERVICE

G7S

DOS: 11/29/2007 8:57:25

REASON: DIABETIC,CHF

EXAMS:

CHEST IV PORT XR

PATIENT:

FITZWATER, JACKIE L

ORDER NUMBER:

4452436

CHEST

Portable semi-upright view of the chest performed 11/29/2007 at 0850 hours a pacemaker in position. There is a central line or an Infuse-A-Port entering from the right with the tip in good position in the superior vena cava. There is blunting of the right costophrenic angle which appears chronic. The lungs appear free of any acute process.

CONCLUSIONS:

1. Chronic thoracic findings.

D: 11/29/2007 09:21 James T Smith MD

T: 11/29/2007 09:40:39 AM tem

Job: 9344526

Dictated By: JAMES T. SMITH, MD

Verified By: JAMES T. SMITH, MD

Verified On: 2007/11/29 11:44:32.00

Transcribed: ESCRIPTION 11/29/2007 09:41

Result ID / Addendum: 3530245 / 0

Patient Name: FITZWATER, JACKIE L

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE:
ATTENDING PHYSICIAN: Dr.

DOB: 04/25/36

UNIT #: D000038770

DISCHARGE DATE:

DISCHARGE DIAGNOSIS:

1. Cor pulmonale with marked right-sided heart failure.
2. Pneumoconiosis.
3. Atrial fibrillation.
4. Chronic obstructive pulmonary disease.
5. Ascites secondary to #1.
6. Probable cirrhosis.
7. Angiodysplasia of the intestines with recurrent chronic hemorrhage.
8. Diabetes mellitus.
9. Recurrent anemia secondary to chronic gastrointestinal bleed.

DISPOSITION:

The patient is discharged home, 1800 calorie diabetic diet. The patient will have a followup appointment in two weeks.

MEDICATIONS:

Nexium, 20 mg. b.i.d.
Torsemide, 100 mg. b.i.d.
Iron, 300 mg. t.i.d.
Levothyroid, 225 mg. daily.
Allopurinol, 100 mg. daily.
Lanoxin, .125 mg. daily.
Glyburide, 5 mg. daily.
Flomax, .4 a day.
Albuterol Atrovent nebulizers.
Spironolactone, 100 mg. twice a day.
Warfarin, 5 mg. in the evening.
Chantix, 1 mg. daily.
Lortab, 5/500 p.r.n.

SUMMARY:

This is one of many admissions for this gentleman with severe end stage cardiopulmonary disease. He had increase in swelling, ascites developing. He has recurrent GI bleeds due to angiodysplasia of the small bowel. He has been worked up currently in Charleston and has just finished a capsule endoscopy. He presented with approximately 20-pound weight gain with increasing shortness of breath and fatigue.

On presentation he was markedly edematous with 3 to 4+ pitting edema. Findings consistent with ascites. Lung fields showed decreased breath sounds. Cardiac showed his valve click. He had no evidence of obvious bleeding although stools are heme positive at this time.

He was admitted, initially started on IV Lasix but did not seem to get much of a diuresis. Because of this, he was converted over to IV Bumex. We also found that he

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE:
ATTENDING PHYSICIAN: Dr.

DOB: 04/25/36
DISCHARGE DATE:

UNIT #: D000038770

had a very high aldosterone level and was placed on Aldactone for purposes of blocking this response. Basically we got about 10 pounds off him here in the hospital and he did well. He did require transfusions as his hemoglobin down to 7. He was about 9.8 when he left at this time. Creatinine stabilized at 2. BUN was in the 40 to 50 range. At this time he is improved. We have made some major changes to his current therapy. He is going to be discharged home and will followup on an out-patient basis.

Lynn N. Smith, M.D.

D: 08/04/07 0917
T: 08/06/07 1305
MAF
PMT, Inc. #12564
cc:

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 07/13/07 at 0742

LOCATION: Third floor.

SUBJECTIVE: Mr. Fitzwater really does not feel bad. He still has some shortness of breath. He has a little bit of pain in his legs and he has also had some mild constipation. No other chest pains or palpitations. He has had minimal cough with no sputum production.

OBJECTIVE: BP is 104/70. His weight is down to 217 so we have got about 5 pounds off but very little given the degree of diuresis this gentleman has been receiving. He still has his ascites with a very protuberant abdomen. Valve click is unchanged, some mild dullness at his lung bases are noted. He still has 2 + pitting edema no evidence of active cellulitis. He has mild peripheral neuropathy and some tenderness in his lower extremities which is not unusual for him.

LABORATORY: His echo shows that his pulmonary hypertension is no worse only about 50 to 55 and his LV function is good and RV function is good. Last hemoglobin was up to 8.8. Other electrolytes and labs are pending from this morning.

IMPRESSION:

1. Cor pulmonale with right sided findings.
2. Valvular heart disease.
3. Diabetes.
4. Recurrent gastrointestinal bleeds with AV malformations - please note that his recent capsule endoscopy performed in Charleston does show evidence of recurrent small bowel AVM's with active bleeding.

PLAN:

1. Get an ultrasound of his legs and his IVC to make sure that there is no obstructive phenomenon.
2. We will put him on some Milk of Magnesia and Citracel for his constipation and Lortab 5 mg. b.i.d. prn for his leg pain.
3. His BMP, mag and protime are pending as of this morning.

Lynn N. Smith, M.D.

D: 07/13/07 0747

T: 07/13/07 1008

MKM

CC:

PMT, Inc. Job #: 06282

RECEIVED JUL 16 2007

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 07/15/07

Time: 0910.

Location: 3rd Floor

SUBJECTIVE:

The patient says that he feels better. He had better strength in his leg today. He is denying any chest pains or shortness of breath. His weight keeps coming down gradually, at about a pound per day. He is voiding well he says. He says he is having less complaints. He says his legs are not as tight. He says his abdomen is not as tight. His appetite has been good. Bowels have been working well. He has been ambulating only minimally at this time.

OBJECTIVE:

His weight is down to about 216. Blood pressure is good at 122/70. Pulse is in the 70's. Lungs: Decreased breath sounds at the right base, with his known chronic effusion. Cardiac: His valve click and murmurs are unchanged. He still has a very protuberant abdomen. Edema: Has improved distally. He still has some, but the legs, are not tight, and the overall edematous pattern has improved. His last labs showed that his BUN and creatinine were still acceptable, with a little more room for more aggressive diuresis. His blood sugars have been under good control. His hemoglobin is up to 9.6 after transfusion.

IMPRESSION:

1. Cor pulmonale.
2. Recurrent GI bleed, secondary small bowel AVM.
3. Prosthetic valve.
4. Pneumoconiosis.
5. History of recurrent cellulitis.

PLAN:

1. We are going to increase his Bumex to 4 mg IV twice daily.
2. We are going to continue with his other diuretics in combination.
3. He is going to have a repeat of his BMP today.
4. We may consider discharge tomorrow, if he continues to diurese and is stable at this time.

Lynn N. Smith, M.D.

D: 07/15/07 0915

T: 07/16/07 0653

LAM

PMT, INC. JOB#06802

cc:

RECEIVED JUL 17 2007

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 07/08/07

Location: 3rd Floor

SUBJECTIVE:

Mr. Fitzwater actually feels a little bit better. He got upset yesterday, because he did not feel he was getting enough food to eat, and the quality was not to his satisfaction. He actually went down and talked to Dietary, so hopefully, they have that resolved. He has been voiding well, but his weight really has not changed much. His shortness of breath has improved. He has not had any other major complaints, such as pain, bleeding, etc.

OBJECTIVE:

His blood pressure is stable at 128/70, with a pulse of 70. Lung fields show decreased breath sounds at the right base. He has a valve click with a mild systolic murmur. He still has significant ascites. 2+-3+ pitting edema is still present, that has not seemed to change much. His weight has not changed significantly over the past forty-eight hours. His sugars have been under good control. His electrolytes have not changed. His potassium is stable at 4.2. Hemoglobin has reduced slightly at 8.4.

IMPRESSION:

1. Cor pulmonale with marked ascites.
2. Chronic anticoagulation with prosthetic valve.
3. Diabetes mellitus.
4. Recurrent GI bleed, secondary to AVM with mild anemia.

PLAN:

1. We will give him a dose of Zaroxolyn orally before his next Lasix.
2. We will get a repeat echo to repeat his pulmonary hypertension.
3. He is going to continue with his other diabetic management and very close monitoring of his H&H.

Lynn N. Smith, M.D.

D: 07/08/07 0906

T: 07/08/07 1046

LAM

PMT, INC. JOB#04866

CC:

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: DR. Lynn N. Smith

DATE: 07/07/07

Time: 0849.

Location: 3rd Floor

SUBJECTIVE:

Mr. Fitzwater had a good night. He slept better. He has a little bit of nausea. No vomiting, no diarrhea. He has been diuresing well at this time, however, his weight is still about 221 lbs today. We have not weighed him in the last day or so, we do not know really if that is a major change. He does feel that his abdominal girth has gone down some. He has no other new complaints at this time.

OBJECTIVE:

Blood pressure is good at 118/70, with a pulse of 74. Lung fields show decreased breath sounds at the right base. He has a valve click with his mild murmur. No other changes. He still has significant abdominal distention with ascites. He has 2+-3+ pitting edema of the distal extremities. His CT scan did show evidence of moderate ascites with probable cirrhotic changes of the liver. Work up has been started to make sure this is not related to some other ongoing process, especially since he has had so much in the way of transfusions.

IMPRESSION:

1. Cor pulmonale, with right-sided failure.
2. Nausea and vomiting with ascites.
3. Valvular heart disease.
4. Diabetes mellitus.

PLAN:

1. We are going to increase his diuresis with Lasix 120 mg IV.
2. He will have a urine sodium, potassium today.
3. Continue with his Aldactone 50 mg b.i.d.
4. He is going to have his Coumadin continued.
5. He will continue on the Lovenox, until such time he has a therapeutic INR.

Lynn N. Smith, M.D.

D: 07/07/07 0853

T: 07/07/07 0916

LAM

PMT, INC. JOB#04713

CC:

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.303

UNIT #: D000038770

ADMISSION DATE: 07/05/07

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: This 71 year old has multisystem disease. He presents to the office today with complaints of nausea, vomiting. He has had this over about the last 24 hours. They have also noticed about a 7 pound weight gain with increasing peripheral edema. He has had increasing shortness of breath, weakness to the point that he is having difficulty with ambulation. We recently saw him in the office and tried to make some changes. He has elevated aldosterone levels. We tried to get him back on his Aldactone and off his metolazone. However despite being on 120 of Lasix twice a day and the Aldactone he has gained about seven pounds in weight, has noted some increasing peripheral edema, fluid and overt findings of worsening of his cor pulmonale.

PAST MEDICAL HISTORY: He has recurrent GI bleeds due to small bowel AVM's. He has a history of CHF, COPD with pneumoconiosis. He is a type 2 diabetic. He is status post aortic valve replacement due to rheumatic heart disease. He has had an episode of restrictive pericarditis. He has had two episodes of toxic shock syndrome, one episode of acute renal failure and has evidence of mild renal insufficiency. He has a history of chronic atrial fibrillation on anticoagulation therapy.

PAST SURGICAL HISTORY: He has had a permanent pacemaker placed, pericardial stripping. He has had an appendectomy, cholecystectomy and prostate microwave surgery. He has also had his aortic valve replaced. He has also had a circumcision within the last couple of years.

ALLERGIES: none known.

CURRENT MEDICATIONS: Well listed and include allopurinol, Nexium, Flomax, Aldactone, Lasix, Synthroid, Lanoxin, Glyburide, Reglan, iron, warfarin.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He quit smoking and has been on Chantix now for about the last two months. No significant alcohol use.

FAMILY HISTORY: Markedly positive for hypertension, diabetes and heart disease.

REVIEW OF SYSTEMS: Weight is up 7#. He denies fevers or chills. He has had some ecchymotic areas on his arms and chronic stasis changes in his legs. He has had no difficulty in swallowing. He has had no dizziness or visual complaints. GI: he has had the nausea with one episode of vomiting. He always has sort of dark stools partly due to his iron and has chronic blood loss. He has had some epigastric and some lower abdominal pain, cramping in nature. Cardiac: he has noted increasing shortness of breath, minimal PND, marked increase in fluid both in his legs and in his trunk.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L (Continued)
UNIT #: D000038770

Respiratory: no cough, sputum or pleurisy. GU: he denies any dysuria or frequency. He has been voiding well at this time. Neuro/psyche: he has had no confusion or disorientation. He has no history of any real depression.

PHYSICAL EXAM: His weight is 218#, blood pressure 120/60 with heart rate of 70. Skin shows some mild ecchymotic areas on his arms. He has chronic stasis changes. Pupils are equal and reactive. Posterior pharynx is clear. Good carotid upstrokes without audible bruits. Thyroid is not enlarged. He has decreased breath sounds in his right base. He has an irregular rate and rhythm with a Grade II murmur. He has his valve click, no diastolic component. His abdomen is markedly enlarged, bowel sounds are normoactive, minimal tenderness to deep palpation in the left lower quadrant. Rectal is not performed. Extremities show 2+3+ pitting edema. He has sacral edema that is pitting at this time. Neurological: he has no reflexes in ankles nor in his feet. He has no focal motor change at this time.

LABORATORY: Hemoglobin is stable at 9.8, INR slightly low at 2.0. The remainder of his labs are pending.

IMPRESSION:

1. Nausea, questionable etiology
2. Congestive heart failure with severe cor pulmonale
3. Status post aortic valve replacement
4. Chronic atrial fibrillation
5. Pneumoconiosis
6. Diabetes

PLAN: He is admitted at this time for more aggressive diuresis. We will get a complex metabolic panel, increase his warfarin to get his anticoagulation a little better. Long term prognosis is guarded.

Lynn N. Smith, M.D.

D: 07/05/07 1747
T: 07/05/07 2023
JNM

cc:

PMT, Inc. Job #: 04246

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L. DOB: 04/25/36
ROOM #: D.330 UNIT #: D000038770
ADMISSION DATE: 03/29/07
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: This is a 70 year old with multi-system disease who has been hospitalized on numerous occasions. His principal problem this time is that he has a history of recurrent GI bleeds due to AV malformations. He has had a history of pulmonary hypertension, cor pulmonale because of a combination of restrictive lung disease and valvular heart disease. He began having increasing weakness, shortness of breath. He was just transfused three weeks ago with blood because of the anemia. He has chronic bleeding. Unfortunately he also has to be chronically anticoagulated because of his prosthetic valve so we basically have never been able to stop this process. He began having increasing shortness of breath. He has been staggering, could not walk, dyspneic and was brought to the ER where he was found to have a hemoglobin of 7.5. He denies any chest pains. His shortness of breath is worse with exertion, better with rest. He has not really had any change in his bowel habits. His stools were always black because he was on iron chronically. He is basically being admitted for transfusion and re-evaluation of his bleeding problems.

PAST MEDICAL HISTORY: He has known chronic congestive heart failure with marked pulmonary hypertension. He has COPD/pneumoconiosis. He is a Type 2 diabetic. He has a history of restrictive pericarditis. He has a history of rheumatic heart disease with subsequent aortic valve replacement. He has also had two episodes of toxic shock syndrome with strep cellulitis. He has had history of some renal insufficiency and is on chronic anticoagulation and atrial fib. He has known BPH.

PAST SURGICAL HISTORY: He has had a valve replaced. He has had a pericardial stripping. He has an appendectomy, cholecystectomy, prostate surgery with microwave. He has also had a circumcision and a permanent pacemaker due to tachybrady syndrome.

ALLERGIES: He has no known drug allergies.

MEDICATIONS: List as noted. They are provided for in his records.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He is still unfortunately smoking but only a few cigarettes a day. No significant alcohol.

FAMILY HISTORY: Unremarkable. There is a positive history for diabetes, heart disease, hypertension.

REVIEW OF SYSTEMS:

HEENT: He hears well. Sees well. No difficulty in swallowing.

CHEST: He does have a minimal cough. He has been short of breath recently. He has a known chronic right pleural effusion that is loculated.

CARDIAC: No chest pains, palpitations.

GI: No change in bowel habits. No nausea, vomiting or diarrhea.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

GU: He is voiding quite well now since he has had his microwave surgery.

ENDOCRINE: No polyuria, polydipsia.

SKIN: He has some multiple ecchymotic areas, itching some too for some reason. He tends to scratch and almost has a neurodermatitis at times. He has minimal arthritic complaints with his knees and back. He has prior history of gout.

PHYSICAL EXAMINATION: He is alert and oriented. His blood pressure is about 120/70 with respirations 20. He is very pale. He has some ecchymotic areas on his skin, on his arms and his legs due to his trauma. No petechial rashes noted.

HEENT: Posterior pharynx is clear. Membranes are dry.

NECK: Supple. Thyroid is not enlarged and his carotids are normal.

LUNGS: Decreased breath sounds at the right base chronically but he has no other rales or rhonchi. He has a valve click with a systolic ejection murmur. No diastolic component at this time.

ABDOMEN: Obese. Bowel sounds are active, no organomegaly, tenderness or bruits.

EXTREMITIES: Warm. He has only minimal edema for him which is quite a bit, improved. He has chronic stasis dermatitis on his legs but there is no evidence of active weeping. No open lesion.

NEUROLOGICAL: He is alert and oriented. He moves his extremities but is diffusely weak. He has severe neuropathy. He has virtually no feeling in his knees distally. This gentleman really just cannot feel because of a severe neuropathy. Also has a little numbness in his right hand. No focal motor abnormalities.

His hemoglobin is 7.5; platelets and white count normal. BUN 80 with creatinine 2.5. EKG shows atrial fib. Chest x-ray is unchanged.

IMPRESSION:

1. Anemia with history of recurrent GI bleed.
2. Restrictive pericarditis with severe cor pulmonale and pulmonary hypertension.
3. Pneumoconiosis.
4. Chronic atrial fib.
5. Valvular heart disease, status post aortic valve replacement.
6. Diabetes Type 2.
7. Severe peripheral neuropathy.

PLAN:

We are admitting him at this time, w/ill transfuse him. Will try to get a bleeding scan to see if perhaps there is enough blood loss now that might trigger what part of the bowel we are losing it in. We will monitor his pro time and try to keep him at

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

the lower limits of acceptability for him. He is going to continue with his other routine meds. Will hold his diuretics for now since his BUN and creatinine are so high and watch his daily weights.

Lynn N. Smith, M.D.

D: 03/29/07 1757
T: 03/30/07 0742
MAF
PMT, Inc. #06810
cc:

RECEIVED APR 10 2007

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/02/07

DISCHARGE DATE: 01/06/07

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure with cor pulmonale, predominantly right-sided failure.
2. Valvular heart disease status post prosthetic valve replacement.
3. Diabetes mellitus type 2.
4. History of chronic GI bleeding secondary to AVM.
5. History of restrictive pericarditis.
6. History of atrial fibrillation.
7. Hypothyroidism.
8. History of benign prostatic hypertrophy.

DISPOSITION: The patient is discharged home to the care of the family. His current meds at this time are going to include Zaroxolyn 5 mg daily, Lasix 20 mg b.i.d., Glyburide 7.5 mg twice a day, Warfarin 7 mg a day, potassium 20 mEq b.i.d., Synthroid 0.225 mg daily, Flomax 0.4 mg daily, O2 at 3 liters, Reglan 10 mg t.i.d. prn, Nexium 20 mg once a day, Lanoxin 0.125 mg daily, Iron and Vitamin C supplementation. He was given a return appointment in two weeks for followup.

SUMMARY: This one of many admissions for this 70 year old with known severe congestive heart failure. He has diastolic failure with both right-sided and left-sided failure history. He gained 15 to 18 lbs with increasing shortness of breath, edema and weakness. He had been adjusted with outpatient medicines with both high dose Lasix and Zaroxolyn, but despite this had increased his swelling. He has a history of severe congestive heart failure, pneumoconiosis, pulmonary hypertension and cor pulmonale.

On presentation, he was alert. He had been given IV Lasix and was diuresing. BP was 130/70, pulse 90, respirations 22. He had a rash on his neck consistent with some posterior folliculitis. HEENT was unremarkable. he had decreased breath sounds with expiratory wheezes and dullness at his right base with a chronic effusion. He had a valve click with no new diastolic murmurs. I count not hear an S3 gallop. He had mild ascites with a possible fluid wave, 2-3+ pitting edema, sacral edema and scrotal edema. Distal extremities were very red. They were swollen, but no really open. There was the beginning of a little bit of serous drainage.

HOSPITAL COURSE: He was admitted and was started on aggressive IV diuresis with Lasix 120 mg twice a day. We placed him on Aldactone at 50 mg twice a day and adjusted his electrolytes. His BNP was low as 128. Digoxin and Magnesium were therapeutic. Hemoglobin was 9.1 which is basically stable for him. Basically, he diuresed nicely, losing about 15 lbs. Shortness of breath improved. Edema improved. Ambulation improved. His electrolytes remained stable, although his BUN was still

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/02/07

DISCHARGE DATE: 01/06/07

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

slightly elevated at the time of discharge. He is discharged home in improved condition, although he has long term chronic illnesses that surely will not resolve at this time.

Lynn N. Smith, M.D.

D: 01/11/07 0733

T: 01/12/07 1300

VGC

PMT, INC. #14905

***** DISCHARGE SUMMARY *****

RECEIVED JAN 15 2007
185

Dictating Physician's copy / STATUS: Draft

App.000449

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.320 UNIT #: D00C03C77C
ADMISSION DATE: 01/02/07
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY OF PRESENT ILLNESS: This is one of many admission for this 70 year old gentleman who has multisystem disease. He has severe pulmonary hypertension, restrictive pericarditis and history of recurrent congestive heart failure predominantly diastolic in origin. Over the last two weeks he has had increasing shortness of breath, weakness, increasing edema. He has gained probably 15-18 pounds during this time frame. He had adjustments in his outpatient medicines. He has been on two different medicines now with both Zaroxolyn and high dose Lasix but has continued to have increased swelling and shortness of breath. He presented to the hospital with these findings, was noted to have marked increasing peripheral edema, now 3-4+ with sacral edema and some scrotal edema beginning.

PAST MEDICAL HISTORY: He has a history of severe congestive heart failure due to a combination of pulmonary hypertension, pneumoconiosis and cor pulmonale. He is a type 2 diabetic. He has had a history of recurrent GI bleed secondary to small bowel AVM's. He has had known restrictive pericarditis. He has had a history of rheumatic heart valve disease with subsequent replacement. He has also had two different episodes of toxic shock syndrome associated with strep cellulitis. He has a history of mild renal insufficiency. He has a history of atrial fibrillation and BPH.

PAST SURGICAL HISTORY: He has had a pacemaker due to tachybrady syndrome. He has had a valve replaced, aortic due to rheumatic heart disease. Subsequent pericardial stripping and a pericardial window. He has had appendectomy, cholecystectomy. He has had prostate surgery with microwave. He has had a circumcision.

ALLERGIES: No known drug allergies.

MEDICATIONS: Please see those listed. They are numerous but they are available in his records.

SOCIAL HISTORY: He is retired from coal mines. He lives at home with his wife. He is still actively smoking, at least 2-3 cigarettes a day. Has a 40 pack year history. No significant alcohol.

FAMILY HISTORY: Is unremarkable.

REVIEW OF SYSTEMS: He has no difficulty in seeing, hearing or swallowing. He has had a cough with clear sputum production. He has had increasing shortness of breath with PND. He has noted increasing peripheral edema. He has had no nausea, vomiting or diarrhea. He has had no further dysuria or frequency. He has done well since he has had his microwave surgery. He has had some mild polyuria although he says his sugars have been well controlled. He denies any arthritic complaints. He has had a history of gout but he has had no active process. He has had some redness to his

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000039770

(Continued)

skin. He has also had a little bit of a rash on his neck that he has had problems with in the past with some folliculitis.

PHYSICAL EXAM: He is alert, oriented. He has been given some IV Lasix and is diuresing at this time. BP 130/70 with pulse 90, respirations 22. He has a rash on his posterior neck consistent with some mild folliculitis. Pupils equal and reactive. Posterior pharynx is clear. Good carotid upstrokes. No thyroid enlargement. He has decreased breath sounds at his bases with expiratory wheezing bilaterally. He has dullness to his right base with known chronic effusion. He has his known valve click. He has no new diastolic murmurs. I cannot hear an S3 gallop. His abdomen is markedly obese. There is probably ascites present. I cannot really be sure about a fluid wave. The liver is minimally palpable. He has 2-3+ pitting edema bilaterally, sacral edema and early scrotal edema. Decreased pulses. His distal extremities are very red. They are not hot or broken open and I don't see any evidence of any serous drainage at this time.
Neurologic: He is alert and oriented. He can move all extremities well. He has severe peripheral neuropathy.

IMPRESSION:

1. CHF with cor pulmonale.
2. Severe pulmonary hypertension.
3. Valvular heart disease.
4. Diabetes mellitus.
5. Hypothyroidism.
6. BPH with outlet obstruction.

PLAN: He will be admitted for more aggressive diuresis at this time. We will monitor his electrolytes which are a little abnormal right now. His K is down to 3 and his sodium is 128, BUN 37, creatinine 1.5. BNP is actually low at this time. Digoxin and magnesium are therapeutic. Hemoglobin 9.1 which is basically pretty good for him. We will aggressively manage his failure and correct electrolytes at this time.

Lynn N. Smith, M.D.

D: 01/02/07 0740

T: 01/02/07 0746

LMC

PMT, Inc. Job # 12218

RECEIVED JAN 03 2007

Patient Name

Jackie Fitzwater

Age

70

Date

1-18-07

Lynn N. Smith, M.D.

Doris A. Ragsdale, M.D.

Chief Complaint

R/O

Pertinent Past Medical History

JACKIE FITZWATER**1/18/2007**

S: Mr. Fitzwater is back in today. He has been doing fairly well at home. He says his weight has been stable. He was hospitalized with his cor pulmonale and he is on his regular medications now and they say his weight has been within 1 to 2 pounds. He still actively smokes about a half pack of cigarettes a day. He still has his dyspnea and his cough. He has not had any major complaints with his legs and overall functional activity has remained about the same.

REVIEW OF SYSTEMS: No chest pains or palpitations. He has not had any PND. He has noted still his peripheral edema. Note, he has had some obstipation issues intermittently and was taking some medicines, but not drinking very much water, because we did have him on some fluid restrictions. His last pro time was just drawn a couple days ago and is good at 3.7 INR.

LMP

Injury

Rhinitis

FAMILY HISTORY

PHYSICAL EXAM:

Ht

Wt

BP

Pulse

Temp

Resp

LAB

EXAMINATION: He is in good spirits. He is walking in his walker. Blood pressure is good at 132/80. His weight here is 222, at home they say it is 211 and stable since discharge. He still has significant edema in his legs. He even has some in his thighs and back region. Lung field shows decreased breath sounds at his right base. His valve click is unchanged and his rate is controlled with chronic atrial fib. He has no abdominal masses or tenderness, but he is fairly obese.

IMPRESSION:

1. Severe pulmonary hypertension with cor pulmonale.
2. History of restrictive pericarditis.
3. Diabetes type 2.
4. Pneumoconiosis/COPD.
5. History of severe peripheral neuropathy.

PLAN: We are going to continue with his current therapy. We will get a CBC and a basic metabolic panel drawn in a week or so when his pro time is due again. We are going to give him the nitroglycerin spray that I want him to try to use for his neuropathy. There is some data that shows that this may well be effective in the severe ones associated with diabetes. I have told him to limit it to 2 sprays, 1 on each foot and to rub it into the area that is effected. We will see if this makes any difference with his overall neuropathic complaint. He will follow up in 1 month. I have also written a prescription for Chantix on the outside chance that this gentleman may quit smoking. I do not have a lot of faith for that, but I think it is quite possible.

Lynn N Smith, MD/NM/aw

Patient Name Jackie Fitzwater Age 70 Date 10/25/06 Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.

Chief Complaint Hosp. Sup

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change

Fever

Chills

CARDIOVASCULAR

Chest Pain

SOB

Palpitation

RESPIRATORY

Sputum

DOE

Pleurisy

GASTROINTESTINAL

Abd Pain

Diarrhea

Constipation

JACKIE FITZWATER

10/25/2006

S: Jackie was recently hospitalized over the weekend with his anemia. He is down to 7.9. He did receive two units transfusions. He thought he was up to 10 and he basically has put on about 20 pounds in fluid during this time frame. He is also still actively smoking several cigarettes a day, according to his daughter.

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 215.5 BP 110/54 Pulse 86 Temp _____ Resp _____

EXAM

Normal

Abnormal

Comment

LAB

A/C

Review of Systems: He has had some increasing shortness of breath. The weight has increased significantly since his last visit. He is not having active bleeding as far as hematochezia, melena. He has not had any more abdominal wall tenderness. That seems to be gradually resolving in that ecchymotic area. The hematoma has gone down quite a bit. No chest pains or palpitations. Minimal cough.

EXAMINATION: His weight is up 20 pounds, now back up to 212. His blood pressure is good today at 118/60. His lungs are pretty clear. He has his decreased breath sounds at the right base with his chronic effusion. Cardiac murmur and click is unchanged. He is about 1 to 2+ pitting edema again on his legs. His most recent labs show that his creatinine is 1.6 with a BUN of 40. His hemoglobin is up to 10. Potassium was slightly low at 3.3.

IMPRESSION:

1. Severe cor pulmonale with pulmonary hypertension.
2. Diabetes mellitus.
3. Recurrent gastrointestinal bleed secondary to arteriovenous malformation.
4. Prosthetic valve status post rheumatic heart disease.

PLAN: To increase his Lasix back to 120 three times a day. Fluid restriction him to about 1200 mL. He is going to continue with his other medical management for now. Increase his potassium by one. I am going to have him follow up in about two weeks. Daily weights.
Lynn N Smith, MD/NM/aw

Patient Name Jackie Fitzwater Age 70 Date 9/5/06 Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.

Chief Complaint F/O -

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

RESPIRATORY

GASTROINTESTINAL

Abd Pain

JACKIE FITZWATER

9/5/2006

S: Jackie is back in. He did go to Charlottesville and they confirmed the fact that he has severe pulmonary HTN, which is causing his cor pulmonale. They put him on a new medication called Rebaito, which is basically a low dose of the Viagra to help with his severe pulmonary HTN. We are now just recently got that approved through his insurance, but he hasn't got it as of yet. He is due for his prostate surgery tomorrow. We have had him off of his Coumadin on the injections with his Lovenox. He will hold the dose tonight and tomorrow morning and then we will restart it tomorrow evening. His weight is actually down to 196. We have lost a lot of fluid weight in this gentleman. He has been on much higher doses, they got him on the Lasix at 120 3 times a day.

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 196.7 BP 124/50 Pulse 92 Temp _____ Resp _____

EXAM

Normal

Abnormal

Comment

LAB

A1C

Review of Systems: Appetite has been fair. No nausea, vomiting. He has had no major pain. His shortness of breath has been stable with no change in his PND or orthopnea. His peripheral edema has significantly improved as we would expect with his 20-30 lbs in weight loss. He has had no other GI or GU symptoms and no active bleeding that we can tell.

EXAMINATION: W 196, BP 124/50, P 92. He doesn't appear to be pale. Lung fields are clear.

Cardiac: Irregular rhythm with his valve click that hasn't really changed. Murmurs are not different. He has no abdominal tenderness or masses and he doesn't have any significant bruits. He has 1+ pitting edema, which for him is actually much improved.

His lab work shows that his creatinine is down to 17 with a BUN of 40, which is adequate for him. His hemoglobin is stable at 10.5. Electrolytes are good with his potassium at 3.6. He has no evidence of any overt diabetic changes.

IMPRESSION:

1. Recent GI bleed, believe due to AVM's.
2. Outlet obstruction uropathy.
3. Mechanical prosthetic valve.
4. Severe cor pulmonale with pulmonary HTN.

PLAN: We are going to continue with his current therapy for now. Will have his surgery tomorrow as planned. He will cut his Lasix back to 120 twice a day. We will get him started on the new medicine for his pulmonary HTN, have him restart his Coumadin tomorrow night and have it rechecked every 48 hours.

Lynn N Smith, MD/NM/aw

Patient Name

Jackie Fitzwater 70

Date

6/29/06

Lynn N. Smith, M.D.

Doris A. Ragsdale, M.D.

John W. Galbreath, M.D.

Chief Complaint

Hospital Flu

JACKIE FITZWATER

6/29/2006

S: Mr. Fitzwater is in today. He was hospitalized recently with his cor pulmonale and right sided failure. We diuresed him, he lost about 10 lbs. Unfortunately I think quite a bit has come back since he has gone home. He has been on fluid restrictions and overall he says he feels pretty well. He is weak, but his activity level is about what it was before.

Review of Systems: Appetite has been good. He denies any chest pains or palpitations. He has no major cough. He has some episodic shortness of breath, but his daughter is here today and she basically informs me he is still actively smoking and smoking more now than he was in the recent past.

Obviously this is a major factor and I have explained to him that I am sure part of his problems.

Unfortunately if he continues to smoke there is probably very little we can do to try to make some of these things improved. His peripheral edema has been pretty stable. He is wearing his TED stockings.

GU: He has had a significant change in urinary symptoms. He has to sit down to void. He feels like he has to strain. He doesn't feel like his stream is very good. He has had a history of significant BPH with some bladder outlet problems. He is on multiple meds and he has been followed by neurology, but hasn't been seen there in a number of months.

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 224.2 BP 106/50 Pulse 84 Temp _____ Resp _____ INR 3.7 PT 23.2

EXAM

Normal Abnormal Comment

General _____

Head _____

Eyes _____

Ears _____

Nose _____

LAB

A1C

ALT/LIVER

BMP-CMP

CBC

FLU

EXAMINATION: W 224, BP 106/50, P 84. His PT is 3.7 INR which is therapeutic for him. Lungs are actually pretty clear. He has his decreased breath sounds in his right base, his loculated effusion. He

is atrial fib with his valve click, which is not changed. His peripheral edema is maybe 1+, which is stable for him. No skin breakdown, erythema or cellulitis. We have done a post void urinary ultrasound, which shows a significant residual, probably 5 to 600 cc.

IMPRESSION:

1. Cor pulmonale.
2. COPD.
3. Urinary retention.
4. History of restrictive pericarditis.
5. Diabetes mellitus.

PLAN: We are going to send him over at this time for urology to put a foley in and we will probably have some more definitive treatment on his prostate after this decompresses. We are going to leave him on the same medication for now. Have him wear his oxygen on a regular basis. He is going to follow up in 2-3 weeks.

Lynn N Smith, MD/NM/aw

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.320

UNIT #: D000038770

ADMISSION DATE: 08/10/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY OF PRESENT ILLNESS: This is one of many admissions for this 70 year old with severe end stage right sided heart failure. This gentleman has severe cor pulmonale due to pneumoconiosis, history of restrictive heart disease from restrictive pericarditis after surgery. He had been home, has gained probably 20 to 25 pounds of fluid over the last two weeks despite aggressive diuresis. He now has diffuse anasarca with pitting edema up into his abdominal wall, almost up into his axillary regions. He has had increasing pain in his legs, he has some weeping now and is brought back in for again, more aggressive diuresis.

PAST MEDICAL HISTORY: Renal insufficiency, pneumoconiosis, cor pulmonale, diabetes type 2 on oral agents, history of restrictive pericarditis. He has known mechanical valve, status post heart surgery. He has had a history of recurrent GI bleeding believed due to AV malformations. He has known chronic ataxia with cerebellar dysfunction. He has had several episodes of sepsis due to toxic shock syndrome and acute renal failure due to Strep infections. He also has known severe post inflammatory and diabetic peripheral neuropathy.

PAST SURGICAL HISTORY: He has had an aortic valve replaced due to rheumatic heart disease. He has had a cholecystectomy, appendectomy, pacemaker due to tachybrady syndrome and a pericardial window that has been done due to his restrictive pericarditis.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS are numerous and listed at the time of admission on his admission sheet.

FAMILY HISTORY: Both parents are deceased, mother was diabetic, father had heart failure.

SOCIAL HISTORY: He is retired coal miner, lives at home with his wife. He is still actively smoking probably at least 4 to 8 cigarettes a day with a longstanding history of smoking. He has no significant alcohol.

REVIEW OF SYSTEMS: As stated, his weight is probably up about 20 to 25 pounds. He has no fevers, chills or sweats. He has decreased hearing, no difficulty in swallowing.

Cardiac: No chest pains or palpitations. He has really had some increasing shortness of breath but has not been quite as severe. He has had no nausea, vomiting or diarrhea. Stools have been normal. He has not had melanotic stools at this time. He did have a colonoscopy two weeks ago with AVM's that were cauterized by GI.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

He has chronic severe chronic peripheral neuropathy. He has arthritis. No history of any neurological disease, seizures, no polyuria or polydipsia.

PHYSICAL EXAM: He is alert, oriented. Blood pressure is 122/78, pulse is 80, O2 sat is 100% on his oxygen.

Skin shows some chronic stasis changes with erythema but no heat in his lower anterior tibial plateaus bilaterally. He does not have any overt skin breakdown at this time. He does have gross anasarca with 3 to 4+ pitting edema, bowel wall edema, sacral edema at least 2+.

Pupils are equal and reactive. Sclerae and conjunctiva are unremarkable. Posterior pharynx is clear with bilateral plate, no audible bruits. Thyroid is not enlarged. He has rales at his base, particularly right with dullness, minimal left.

He has his valve click with grade 2 murmur, no diastolic component.

His abdomen is obese. There is probably ascites but I cannot be sure at this time. I cannot really feel a fluid wave.

Rectal is not performed. He does have scrotal edema.

Extremities as previously described.

Neurologically he is alert and oriented. He moves all extremities well, very poor sensory exam. He has decreased light touch to sensory and paresthesias in his distal extremities.

LABORATORY: BUN is 50, creatinine 2. His hemoglobin is 8.4, platelets are unremarkable. Chest x-ray shows his chronic right effusion. Electrolytes really are not bad: Sodium is a little low at 127 with a chloride of 87, potassium is good at 4.5. EKG shows his atrial fib with controlled rate.

IMPRESSION:

1. Anasarca with right sided failure.
2. History of restrictive pericarditis.
3. Pulmonary hypertension with pneumoconiosis.
4. History of recurrent GI bleed secondary to AVM's.
5. Chronic atrial fib.
6. Diabetes.

PLAN: He is admitted at this time. We will start him on an IV Lasix drip at 15 mgs

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

per hour. We will keep his other regular meds for now. We will see if we can diurese him without driving his BUN up to high. We will monitor his H&H and transfuse as indicated. Hemocults will be monitored.

Lynn N. Smith, M.D.

D: 08/10/06 2039
T: 08/11/06 0720
VMN

PMT, Inc, Job #3028

RECEIVED 08/11/06

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 08/10/06

DISCHARGE DATE: 08/11/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Acute refractory cor pulmonale.
2. Pulmonary hypertension, severe.
3. Pneumoconiosis.
4. History of prosthetic aortic valve secondary to rheumatic heart disease.
5. Diabetes mellitus.
6. Severe peripheral neuropathy.
7. Post inflammatory neuropathy.
8. Hypothyroidism.
9. History of recurrent GI bleed due to AV malformations of the bowel.

DISPOSITION: The patient is discharged to the services of Dr. Bergen at the University of Virginia for reevaluation. He is going to have a right heart cathe and determination of adjustment on medical management.

DISCHARGE MEDICATIONS: Please the patient's current list.

SUMMARY: This is a 70 year old gentleman with known severe end stage right-sided heart failure with severe pulmonary hypertension, restrictive heart disease. He had gained 25 lbs over the last two weeks despite aggressive diuresis with increasing anasarca, pitting edema and ascites. He had increasing respiratory distress. For this he was brought back to the hospital and rehospitalized. He showed 3+ to 4+ pitting edema with bowel wall edema, sacral edema, at least 2+. He had rales at his bases, right in particular. He had his valve click with a grade 2 murmur which is unchanged. BUN 50 with creatinine 2. Hemoglobin 8.4 with platelets unremarkable. Chest x-ray showed a right-sided effusion.

He was readmitted, was started on IV Lasix drip at 15 mg/hour, continued with his other regular medications. We contact Dr. Bergen at the University of Virginia who accepted the patient and we transferred him the following day to UVA for more aggressive diagnosis and intervention. Prognosis at this time is very poor. It will be questionable as to whether anything else can be done for this gentleman with end stage heart and lung disease.

Lynn N. Smith, M.D.

D: 08/26/06 0921

T: 08/27/06 1210

LMC

PMT, Inc. Job # 07061

***** DISCHARGE SUMMARY *****

RECEIVED AUG 29 2006

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.319 UNIT #: D000036770
ADMISSION DATE: 06/19/06
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: Leg swelling and increased weight and shortness of breath.

HISTORY OF PRESENT ILLNESS: Patient is a 78 year old male who presents to the hospital today, being directly admitted by Dr. Lynn Smith. He has an approximately 1 to 2 week history of increasing weight and increasing swelling into his legs. He states that, however, he started becoming short of breath yesterday and on Saturday his legs started swelling even more to the point where his right leg has opened and is weeping. He states that the above has made it harder for him to get around, that his legs feel very rubbery and since his gait is ataxic anyway he has had a much increased difficulty with ambulating. He denies any orthopnea but does admit to a couple of occasions recently of paroxysmal nocturnal dyspnea. He has a history of heart failure as well as having cor pulmonale. He states that he has been coughing more recently with an increase in white, thick sputum. He denies any fever or chills, he denies night sweats. He denies any nausea or vomiting. The patient has recently been taking his Demadex as prescribed as well as his Zaroxolyn but states that although that has occurred he has continued to gain weight and edema in his legs. The patient also states that he has been on a limited fluid diet of 1200 mls daily for his fluid restriction and that also has failed to keep his edema down.

PAST MEDICAL HISTORY is positive for congestive heart failure, cor pulmonale, COPD, renal insufficiency, peripheral neuropathy, DM type 2, history of restrictive pericarditis, prosthetic aortic valve on chronic Coumadin, anemia, GI bleeding, possibly secondary to erosive gastritis, iron deficiency anemia, hypothyroidism, history of gout, chronic ataxia.

SOCIAL HISTORY: The patient is a one pack per day smoker for at least 50 to 60 years. He is married and lives at home with his wife. He denies the use of alcohol or illegal drugs.

REVIEW OF SYSTEMS: General: He does admit to 12 to 15 pound weight gain over the past week, fatigue weakness, denies fever or chills or night sweats.
Skin: The skin over his legs in the pretibial area has started to blister and weep.
Head: He denies any changes in his vision, no complaint of headache, no complaint of hearing loss, or tinnitus. The patient does have chronic instability/vertigo.
Mouth: The patient has dentures but denies any sores in his mouth or any sore throat or difficulty swallowing.
Respiratory: He does complain of an increase in shortness of breath, also increased cough with increased sputum production, otherwise, as in history of present illness.
Cardiac: He has a history of hypertension, murmur and valvular heart disease. He denies any recent palpitations. He denies orthopnea but does admit to some paroxysmal nocturnal dyspnea.
GI: He states his appetite has not changed. He has not been nauseated or vomiting.

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P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L (Continued)
UNIT #: D000038770

He has had no problems, changes or in frequency of his stool.

Urinary: He has some chronic urinary difficulties for which he is on Flomax but denies any current dysuria.

Vascular: He does complain of an extensive leg edema as well as pain in his legs as well as weakness in his legs.

Musculoskeletal: He has a history of gout but no current joint redness or stiffness or instability.

Neurologic: He has a history of peripheral neuropathies but no complaint of new numbness or tingling.

Hematologic: The patient has been anemic in the past and is on chronic iron therapy.

Endocrine: The patient does have a history of hypothyroidism as well as diabetes.

Psychiatric: No complaint of anxiety or depression.

PHYSICAL EXAM: General: This is a 70 year old male with a fragile state of health. He is in no acute distress and is alert and oriented x 3.

Vital signs on admission: Blood pressure 102/51, temperature of 97.2, pulse of 100, respirations of 20, oxygen saturation of 86%. His skin is warm and dry with occasional scattered wheezes. His head is normocephalic, atraumatic. His pupils are equal and reactive to light and accommodation with no scleral icterus. His nose is symmetric and without discharge. The patient currently is wearing dentures. Mucous membranes are pink and moist. His heart is regular with some slight tachycardia and a grade 2/4 systolic murmur.

His lungs are with scattered wheezes, decreased breath sounds in the bases, some slight coarse rales in the bases.

His abdomen is soft with some slight tenderness in the left upper quadrant but no rebound or guarding, no rigidity, positive bowel sounds.

Genitourinary exam was not performed at this time.

Rectal exam not performed at this time. Both are deferred to his primary care physician.

Musculoskeletal exam: The patient has an ataxic gait and was examined in the bed but he has symmetric grip strength. No instability of joints is noted; however, the patient has very poor balance chronically. The patient has right leg calf tenderness.

Vascular: Radial pulses are diminished at +1/4. The patient has 3+ pitting edema all the way up to his mid thigh level, also pretibially bilaterally he has stasis dermatitis as well as some weeping and blistering of the right pretibial area, bilaterally the pretibial area is warm but not hot. No obvious areas of induration are noted.

INVESTIGATIONS: The patient will be receiving a chest x-ray, a BMP as well as a BNP, a CBC, a venous Doppler of his right leg.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

ASSESSMENT AND PLAN:

1. CHF.
2. Increased peripheral edema.
3. Cor pulmonale.
4. Valvular heart disease with aortic valve replacement.

PLAN: The patient will be admitted for IV diuretics, a venous Doppler and evaluation of his orthostatic blood pressure. We will continue to watch his edema and see that it resolves. All further details will be noted in the order list.

Lynn N. Smith, M.D.

By _____
Ashley Fritzius, D.O.

D: 06/19/06 1429

T: 06/19/06 1446

VMN

PMT, Inc., Job #19177

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 06/19/06

DISCHARGE DATE: 06/23/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Congestive heart failure with cor pulmonale.
2. Increased peripheral edema.
3. Valvular heart disease status post aortic valve replacement.

DISCHARGE MEDICATIONS: Nexium 20 mg PO b.i.d., Proscar 5 mg PO daily, Glucophage 1000 mg PO b.i.d., Digitek 0.125 mg daily, Klor-Con 20 mEq t.i.d., Levothyroxine 225 mcg PO daily, Lierta 7 mg PO t.i.d., Allopurinol 100 mg daily, Glyburide 5 mg t.i.d., Flomax 0.4 mg PO b.i.d., Torsemide 100 mg PO b.i.d., Iron one tablet daily, Vitamin D one tablet daily, nebulizers as prior to admission, Zaroxolyn 5 mg PO 30 minutes prior to Demadex.

DISPOSITION: The patient was discharged home into the care of his family. His diet is to be as prior to admission with a 1500 ml fluid restriction. His activity is to be as tolerated and as prior to admission. He is to followup with Dr. Smith in one to two weeks and to have daily weights.

SUMMARY: This is a 70 year old male who presented to the hospital who presented to the hospital after being directly admitted by Dr. Lynn Smith with a two week history of increasing daily weights as well as increasing peripheral edema. The day before admission, he started becoming short of breath and his leg swelling increased even more to the point where his right leg began to open and weep. He stated that he has become more orthopneic as well as having some occasions of paroxysmal nocturnal dyspnea. He has had an increase in his cough as well as thick white sputum. He denied any fever or chills. No nausea or vomiting. However, he did fail adjustment in his outpatient therapy with Demadex, Zaroxolyn and Aldactone.

LABORATORY: He had a chest x-ray that showed mild cardiomegaly, no DVT on his duplex Doppler scan. His white count wa 9.1, hemoglobin 9.2, hematocrit 28.9 and platelet count 173,000. His BMP was 127 and potassium 3.8, chloride 88, CO2 33.8, glucose 203, BUN 48, creatinine 1.8, calcium 8.1 with a BNP of 63.7. His PT/INR was 22.6 and 3.41.

HOSPITAL COURSE: The patient was admitted for IV diuretics and management of his heart failure. On the day after his admission, he was also started on a prophylactic dose of Clindamycin IV secondary to his tendency towards infection in the previously traumatized area of his right leg. He was put on a fluid restriction on the 21st. His FCDs were placed on his legs and on the 22nd, we also decided that compression stockings would be appropriate. The compression stockings were of great assistance and his fluid really began to mobilize. He had a weight decrease at this point of 9 lbs and it was decided on the morning of the 23rd, that the patient was ready for discharge. His breathing was improved. His peripheral edema was improved. His cough was improved. His ability to ambulate was improved. It was decided that the

***** DISCHARGE SUMMARY *****

RECEIVED JUN 26 2006

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 06/19/06

DISCHARGE DATE: 06/23/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

patient had reached the maximum of his hospital benefit and he was discharged to home. He will be following up as an outpatient with Dr. Lynn Smith in one week or as needed with an appointment given for July 6 at 10:15 in the morning. He is to continue with the TED hose at home as well as the 1500 ml fluid restriction and his daily weights. He is to let us know if he has any further problems.

Lynn N. Smith, M.D.

Dictated by Ashley Fritzius, D.O.

D: 06/23/06 1333

T: 06/24/06 1146

VGC

PMT, INC. #20330

***** DISCHARGE SUMMARY *****

Dictating Physician's copy / STATUS: Draft

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200
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VALLEY MEDICAL ASSOCIATES, INC.

RT. 2, BOX 171

LEWISBURG, WV 24901

PH 304-645-3207 FAX 304-645-3128

ECHOCARDIOGRAM REPORT

JACKIE FITZWATER DOB: 04/25/1936

Referring Physician: Dr. Lynn Smith

Sonographer: Karen Webb

Date of Echo Study: April 12, 2006 with suboptimal acoustic windows. Repeat adequate study May 13, 2006

CLINICAL DIAGNOSIS: St. Jude aortic prosthesis in 1996. Pacemaker.

ECHO QUALITY: Adequate parasternal and suboptimal apical acoustic windows and views due to body habitus and smoking.

M-MODE MEASUREMENTS:

Aortic Root 3.3 cm

Left Atrium 4.3 cm

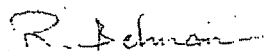
Adequate ventricular measurements were not obtainable.

INTERPRETATION:

1. VALVES: St. Jude's aortic prosthetic valve with normal motion. Mild mitral valve degenerative changes with mobile leaflets. Normal tricuspid valve morphology and motion.
2. CHAMBERS: Mildly dilated left atrium and normal sized right atrium and the ascending aorta. Intact interatrial and interventricular septum. Normal right ventricular dimensions and wall motion and function. Hypertrophied normal size left ventricle with a preserved systolic function based on an estimated global ejection fraction of 60-65%. No intracavitary space-occupying lesion or pericardial effusion. The left atrial appendage, the major source of thromboembolic events in atrial fibrillation was not visualized.
3. PULSED WAVE, continuous wave and color Doppler flow imaging revealed mild aortic regurgitation and systolic gradient across the aortic prosthetic valve ranging from 36 to 42 mmHg not uncommonly seen in normally functioning aortic prosthetic valves and mild mitral and tricuspid regurgitation. TR Vmax to assess pulmonary hypertension was not obtainable.
4. THE CARDIAC RHYTHM is atrial fibrillation with controlled ventricular response.

IMPRESSION: Aortic prosthesis with normal function and hypertrophied normal sized left ventricle with a preserved systolic function.

Sincerely,



Ramsey Behnam, M.D.

RB/ar

RECEIVED MAY 25 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

DOB: 04/25/36

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 08/01/08 at 0730

LOCATION: Third floor.

SUBJECTIVE: Mr. Fitzwater states that he feels well at this time. He has no major complaints other than he is still very weak. He has some dyspnea on exertion. He required two units of blood transfusions yesterday as his hemoglobin was down to 8.5. No pain at this time. He is voiding well and eating fairly well.

OBJECTIVE: His vital signs are stable. BP is 110/70. He has the dullness at his bases. He has his valve click with no new murmurs. His abdomen is obese. He does have pitting edema to the thighs with significant right sided failure. Repeat H & H is pending at this time.

IMPRESSION:

1. Cor Pulmonale.
2. Recurrent GI bleed secondary to small bowel AVM's.
3. Diabetes mellitus.

PLAN:

We have not been able to get him to be transferred to Charlottesville for his GI further evaluation but his heart failure I think is still a progressive problem here. I have contacted cardiology at UVA to see if we might get them to evaluate him from his right sided heart failure standpoint to see what else can be done. We can then arrange for him to be seen via GI services while there and possibly some other procedures done for his small bowel.

Lynn N. Smith, M.D.

D: 08/01/08 0750
T: 08/01/08 1016
MKM

CC:
PMT, Inc. Job #: 23345

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 07/31/08 at 0745

LOCATION: Third floor.

SUBJECTIVE: Patient seems to be feeling well at this time. He is not having any major problems. He is ambulating. He has not noticed any significant change in his bowels or his breathing pattern. We are still waiting for a bed at Charlottesville.

OBJECTIVE: His BP is stable and vital signs are good. Lungs show his decreased breath sounds at his right base. Cardiac shows his atrial fib with his valve click which is unchanged. He still has 2 to 3 + pitting edema and they have not used his pneumatic hose unfortunately.

IMPRESSION:

1. Recurrent GI bleed secondary to small bowel AVM's.
2. Prosthetic mechanical valve.
3. Cor Pulmonale.
4. Diabetes mellitus.
5. MRSA nasal colonization.

PLAN:

1. We will again try to see if a bed will be available at Charlottesville.
2. He is going to continue with his other therapy for now.
3. His pneumatic hose will be restarted.
4. He is back on his diuretics at this time.

Lynn N. Smith, M.D.

D: 07/31/08 0752

T: 07/31/08 0926

MKM

cc:

PMT, Inc. Job #: 23074

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.334

UNIT #: D000038770

ADMISSION DATE: 07/22/08

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: Weakness worsening, confusion, new onset, polychezia, new onset.

HISTORY OF PRESENT ILLNESS: The patient is a 72-year-old white male who was directly admitted to Greenbrier Valley Medical Center by Dr. Lynn Smith. Historians include the patient, his wife Pat and his daughter, Jennifer. The patient has experienced multiple episodes of falling backwards while changing from a sitting to standing position. The most recent episode occurred yesterday when the patient stood to adjust his nasal cannula tubing and recalls himself looking down falling to his knees and landing on the carpeting. He denies hitting his head at that time. Worsening balance has been experienced throughout the past two weeks. This inability to ambulate has become a particular problem the past two days due to the patient's frequent black sticky bowel movements which are occurring hourly including throughout the night. The patient's wife states that she has "played in shit the past two days". There has been associated restlessness at night and tiredness during the day. The family notes that the patient has been markedly confused the past couple of days.

PAST MEDICAL HISTORY: The patient has received surgical repair of his right hip fracture by Dr. Poley of Charleston General in 11/07. BPH has been treated by microwave therapy by Dr. Mouchy in 2006. EGD, colonoscopy performed by Dr. Joe White of CAMC Memorial three weeks at this time. Six small bowel AVM's were cauterized. An additional two AVM's were not able to be cauterized at that time due to their distance from the cautery rod. Esophageal dilatation has been performed by Dr. Casto in 6/08. Incision and drainage of scalp lesion was performed by Dr. Lynn Smith five days ago. Culture is positive for MRSA. The patient is status aortic valve replacement. He is anticoagulated to a goal level of 2.5 INR. Restrictive pericarditis, Type 2 diabetes, mellitus, cor pulmonale, COPD, pneumoconiosis, diastolic induced congestive heart failure, renal insufficiency, chronic atrial fibrillation status post permanent pacemaker, toxic shock syndrome, two episodes, hypothyroidism, prior rehabilitation patient at Heartland Nursing Home of Rainelle. Anemia secondary to recurrent GI bleed.

PAST SURGICAL HISTORY: Permanent pacemaker, pericardial stripping, cholecystectomy, appendectomy, TUR, recent circumcision completed within the last several years. Mechanical prosthetic valve, right hip fixation.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS:

Demadex, 100 mg. PO b.i.d.

Digoxin, 0.125 mg. PO q h.s.

Novolog, 70/30, 20 units subq daily at 7:30 a.m.

Necon, 1/50 tablet PO b.i.d.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Acetaminophen, 50 mg. PO q6 hours p.r.n. for fever or pain.
Albuterol Sulfate, 2.5 mg/0.5 ml. neb as directed.
Nexium, 20 mg. PO b.i.d.
Levoxine, 225 mcg. PO daily at 10:00 a.m.
Allopurinol, 300 mg. PO daily at 10:00 a.m.
Flomax, 0.4 mg. PO b.i.d.
Coumadin, 3 mg. PO daily at 9:00 p.m.
Insulin Glargine, 100 units/ml., 35 units subcu every evening.
Ferrous Sulfate, 325 mg. PO t.i.d.
Spironolactone, 100 mg. PO b.i.d.
Calcium Citrate, 500 mg. PO q.i.d.
O2, 3 liter nasal cannula.
Atrovent, 0.5/2.5 ml. nebulizer as directed.
Lexapro, 10 mg. PO q h.s.
Bactrim, 80/400 mg. PO b.i.d.

SOCIAL HISTORY: The patient is a retired coal miner. He lives with his wife in their home. He receives daily care by his daughter who lives next door. The patient has a longstanding history of smoking but denies smoking during the past eight months. Has no significant alcohol history.

FAMILY HISTORY: Positive for diabetes, premature coronary disease and heart disease. There is no significant cancer history.

REVIEW OF SYSTEMS:

GENERAL: The patient's family states that the patient is contrary and impatient.

HEAD: The patient is bothered by an itchy feeling over the recent I&D performed on his scalp. He denies headaches.

EENT: The patient denies nosebleeds. He states that he does have difficulty swallowing solid foods and that this condition was not improved by his recent esophageal dilatation in June.

PULMONARY: The patient experiences shortness of breath and dyspnea with exertion. He states he regularly coughs with white sputum production and this is diminished when he utilizes his nebulizer treatments.

CARDIAC: The patient has some mild PND. He has marked and consistent peripheral edema to the knee. No chest pain, positive palpitations which have been more noticeable since pacemaker implantation.

GU: Denies dysuria. There is marked frequency to his urination which the patient feels occurs "everytime he turns". He is experiencing nocturia 8 to 10 times per night. Denies hematuria.

ENDOCRINE: Negative polydipsia, positive polyuria.

GI: Negative hematochezia. Negative hematemesis. Slight blood has been noted when

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

wiping hemorrhoidal areas. White mucus has been noted in stools.

NEUROLOGIC: The patient has chronic numbness with severe peripheral neuropathy in his arms, hands and feet. He has no history of stroke. He does have known ataxia with gait abnormalities. He does experience falls frequently. The patient has not had access to a wheelchair since he received his four-wheeler last summer. He has been ambulating at home with a walker.

HEMATOLOGIC: Home care documented hemoglobin of 8.4 and INR of 3.5 yesterday. The patient's Coumadin was held last night.

PHYSICAL EXAMINATION:

GENERAL: The patient is a conversant 72-year-old white male who is oriented to person, place and time and states that he will recline throughout the interview because he is feeling tired. During the interview, the patient consumes two little Debbie cakes and a tootsie roll pop.

HEENT: Head: There is a 2 cm. area of induration at the vertex of the patient's scalp. There is no purulence draining from this site. 1 mm. incision in the center of this lesion is scabbed. The head is atraumatic and normocephalic. Eyes: The patient's pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Non-icteric sclerae. Conjunctivae are pale, pink and moist. Nose negative rhinorrhea. Pink nasal turbinates. Throat: The patient is able to speak clearly and swallow his saliva. There is negative erythema, negative exudate of the posterior oropharynx. Mouth: The patient is edentulous and wearing maxillary and mandibular dentures.

NECK: Supple. There is negative carotid bruit auscultated bilaterally. Negative lymphadenopathy. Negative thyromegaly. Negative jugular venous distention.

HEART: Irregularly irregular. Valve click is present. There is a 3 out of 6 systolic ejection murmur.

LUNGS: Good inspiratory effort, symmetrical diaphragmatic excursion, decreased breath sounds in the apices bilaterally. Wheezes auscultated in the right lower lobe.

ABDOMEN: Protuberant. There are positive active bowel sounds. There is negative palpable pulsatile mass. Negative bruits auscultated. Negative hepatosplenomegaly. Negative hepatojugular reflux. There is tenderness to light palpation of the left supraumbilical region. Negative peritoneal sign.

RECTAL: There are two hemorrhoids protruding exterior to the anal sphincter. These measure 1 inch x 3 mm. No active bleeding is noted at this time.

EXTREMITIES: 4+ pitting edema of the right lower extremity. 3+ pitting edema of the left lower extremity. Dorsalis pedis, peroneal artery and posterior tibialis pulses are non-palpable. Proprioception is intact. Sharp dull discrimination. Hot cold discrimination and vibratory sensation are lacking to the level of the knee.

MUSCULOSKELETAL: The patient experiences bilateral foot drag during his gait. He relies on the assistance of both his walker and his daughter.

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

SKIN: There are multiple ecchymotic lesions on the patient's upper and lower extremities.

IMPRESSION:

1. Weakness, worsening.
2. Confusion, new onset.
3. Polychezia, new onset.
4. Status post recurrent GI bleed due to small bowel AVM.
5. Anemia secondary to #4.
6. Diabetes mellitus 2.
7. COPD with pneumoconiosis.
8. Cor pulmonale.
9. Hypothyroidism.
10. Renal insufficiency.
11. History of diastolic CHF.
12. Prosthetic heart valve.
13. Therapeutic anticoagulation for #12.
14. MRSA positive surgical incision.

PLAN:

The patient is being admitted as an in-patient to Dr. Lynn Smith. His vitals and pulse oximetry will be taken routinely. His activity will be restricted to ambulation only with assistance due to his fall risk. Physical Therapy will ambulate the patient three times daily. His diet will be soft mechanical with ground meats. 1800 calorie ADA, ins and outs will be routine. Will be typed and screened. Fingerstick blood glucoses with meds. Fecal occult blood testing stools times three, bedside toilet, diapers, hep-lock port-A-Catheter, CBC and Complete Metabolic Panel now, haptoglobin, LDH levels, daily PT, INR, incentive spirometry every 2 hours while awake, TED stockings if available, otherwise compression stockings, skin precautions for positive MRSA. Medications will include Demadex, 100 mg. PO b.i.d.; Digoxin, 0.125 mg. PO q h.s.; Novolog, 70/30, 20 units subcu daily at 7:30 a.m.; Necon, 1/50 tablet PO b.i.d.; Acetaminophen, 50 mg. PO q6 hours p.r.n. for fever or pain, Albuterol Sulfate, 2.5 mg./0.5 ml. neb as directed, Nexium, 20 mg. PO b.i.d., Levoxine, 225 mcg. PO daily at 10:00 a.m., Allopurinol, 300 mg. PO daily at 10:00 a.m., Flomax, 0.4 mg. PO b.i.d., Coumadin, 3 mg. PO daily at 9:00 p.m., hold if INR is greater than 3, Insulin Glargine, 100 units/ml., 35 units subq every evening, Ferrous Sulfate, 325 mg. PO t.i.d., Spironolactone, 100 mg. PO b.i.d., Calcium Citrate, 500 mg. PO q.i.d., O2, 3 liter nasal cannula, Atrovent, 0.5/2.5 mg. nebulizer as directed, Lexapro, 10 mg. PO q h.s., Ativan, 0.5 mg. PO at bedtime,

GREENBRIER VALLEY MEDICAL CENTER
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Bactrim, 80/400 mg. PO b.i.d., Neomycin, 0.05% Cream topically to scalp t.i.d. times 7 days, orthostatic blood pressures. A transfusion form will be completed. Results for previous PTH, calcitonin levels will be investigated.

Lynn N. Smith, M.D.

Dictated by R. Lagos, D.O., Intern

D: 07/22/08 1604
T: 07/22/08 1635
MAF
PMT, Inc. #20804
cc:

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE:
ATTENDING PHYSICIAN: Dr.

DOB: 04/25/36
DISCHARGE DATE:

UNIT #: D000038770

DISCHARGE DIAGNOSIS:

1. Acute gastrointestinal bleed superimposed on chronic blood loss secondary to angiodysplasia of the intestine.
2. History of congestive heart failure diastolic.
3. Chronic obstructive pulmonary disease with pneumoconiosis.
4. Diabetes mellitus.
5. Hypothyroidism.
6. Cor pulmonale.
7. Benign prostatic hypertrophy.
8. Iron deficiency anemia.
9. Esophageal stricture.
10. Status post prosthetic valve replacement.

PROCEDURE:

EGD with dilatation

DISPOSITION:

The patient is discharged home to the care of his family. He will resume his regular meds which are listed in the chart. Please see those as they are fairly significant.

This is a 72 year old with multi-system disease who comes in with increasing shortness of breath, weakness and weeping from his legs. He had increase in his right-sided heart failure. He has known recurrent GI bleed secondary to AV malformations. He has severe pulmonary hypertension and cor pulmonale. His weight was up about 10 pounds. On presentation, the patient had a blood pressure of 150/80. He had weeping legs distally that were grossly edematous. He had his valve click with no new diastolic murmurs. He had dullness at his bases. He had a history of some dysphasia and was actually to be seen by Surgery because of this. On presentation, his hemoglobin was 7.6. He subsequently was transfused two units of packed cells resulting hemoglobin into the upper 9's. He felt better. He was seen by Surgery, had an EGD and had an esophageal dilatation done at that time. His INR was kept low therapeutic at his hospitalization. Overall his clinical condition improved. We were able to diurese him. The legs basically quit weeping. Had no evidence of any secondary infection. He is thus being discharged home at this time in improved condition although his long-term prognosis is poor because he is still

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE:

DISCHARGE DATE:

ATTENDING PHYSICIAN: Dr.

actively bleeding and chronically so has to stay on anticoagulation because of his mechanical prosthetic valve.

Lynn N. Smith, M.D.

D: 06/30/08 0747

T: 06/30/08 0815

MAF

PMT, Inc. #14986

CC:

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.330

UNIT #: D000038770

ADMISSION DATE: 07/22/08

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: Weakness worsening, confusion, new onset, polychezia, new onset.

HISTORY OF PRESENT ILLNESS: The patient is a 72-year-old white male who was directly admitted to Greenbrier Valley Medical Center by Dr. Lynn Smith. Historians include the patient, his wife Pat and his daughter, Jennifer. The patient has experienced multiple episodes of falling backwards while changing from a sitting to standing position. The most recent episode occurred yesterday when the patient stood to adjust his nasal cannula tubing and recalls himself looking down falling to his knees and landing on the carpeting. He denies hitting his head at that time. Worsening balance has been experienced throughout the past two weeks. This inability to ambulate has become a particular problem the past two days due to the patient's frequent black sticky bowel movements which are occurring hourly including throughout the night. The patient's wife states that she has "played in shit the past two days". There has been associated restlessness at night and tiredness during the day. The family notes that the patient has been markedly confused the past couple of days.

PAST MEDICAL HISTORY: The patient has received surgical repair of his right hip fracture by Dr. Poley of Charleston General in 11/07. BPH has been treated by microwave therapy by Dr. Mouchy in 2006. EGD, colonoscopy performed by Dr. Joe White of CAMC Memorial three weeks at this time. Six small bowel AVM's were cauterized. An additional two AVM's were not able to be cauterized at that time due to their distance from the cautery rod. Esophageal dilatation has been performed by Dr. Casto in 6/08. Incision and drainage of scalp lesion was performed by Dr. Lynn Smith five days ago. Culture is positive for MRSA. The patient is status aortic valve replacement. He is anticoagulated to a goal level of 2.5 INR. Restrictive pericarditis, Type 2 diabetes, mellitus, cor pulmonale, COPD, pneumoconiosis, diastolic induced congestive heart failure, renal insufficiency, chronic atrial fibrillation status post permanent pacemaker, toxic shock syndrome, two episodes, hypothyroidism, prior rehabilitation patient at Heartland Nursing Home of Rainelle. Anemia secondary to recurrent GI bleed.

PAST SURGICAL HISTORY: Permanent pacemaker, pericardial stripping, cholecystectomy, appendectomy, TUR, recent circumcision completed within the last several years. Mechanical prosthetic valve, right hip fixation.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS:

Demadex, 100 mg. PO b.i.d.

Digoxin, 0.125 mg. PO q h.s.

Novolog, 70/30, 20 units subq daily at 7:30 a.m.

Necon, 1/50 tablet PO b.i.d.

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Acetaminophen, 50 mg. PO q6 hours p.r.n. for fever or pain.
Albuterol Sulfate, 2.5 mg/0.5 ml. neb as directed.
Nexium, 20 mg. PO b.i.d.
Levoxine, 225 mcg. PO daily at 10:00 a.m.
Allopurinol, 300 mg. PO daily at 10:00 a.m.
Flomax, 0.4 mg. PO b.i.d.
Coumadin, 3 mg. PO daily at 9:00 p.m.
Insulin Glargine, 100 units/ml., 35 units subcu every evening.
Ferrous Sulfate, 325 mg. PO t.i.d.
Spironolactone, 100 mg. PO b.i.d.
Calcium Citrate, 500 mg. PO q.i.d.
O2, 3 liter nasal cannula.
Atrovent, 0.5/2.5 ml. nebulizer as directed.
Lexapro, 10 mg. PO q h.s.
Bactrim, 80/400 mg. PO b.i.d.

SOCIAL HISTORY: The patient is a retired coal miner. He lives with his wife in their home. He receives daily care by his daughter who lives next door. The patient has a longstanding history of smoking but denies smoking during the past eight months. Has no significant alcohol history.

FAMILY HISTORY: Positive for diabetes, premature coronary disease and heart disease. There is no significant cancer history.

REVIEW OF SYSTEMS:

GENERAL: The patient's family states that the patient is contrary and impatient.

HEAD: The patient is bothered by an itchy feeling over the recent I&D performed on his scalp. He denies headaches.

EENT: The patient denies nosebleeds. He states that he does have difficulty swallowing solid foods and that this condition was not improved by his recent esophageal dilatation in June.

PULMONARY: The patient experiences shortness of breath and dyspnea with exertion. He states he regularly coughs with white sputum production and this is diminished when he utilizes his nebulizer treatments.

CARDIAC: The patient has some mild PND. He has marked and consistent peripheral edema to the knee. No chest pain, positive palpitations which have been more noticeable since pacemaker implantation.

GU: Denies dysuria. There is marked frequency to his urination which the patient feels occurs "everytime he turns". He is experiencing nocturia 8 to 10 times per night. Denies hematuria.

ENDOCRINE: Negative polydipsia, positive polyuria.

GI: Negative hematochezia. Negative hematemesis. Slight blood has been noted when

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

wiping hemorrhoidal areas. White mucus has been noted in stools.

NEUROLOGIC: The patient has chronic numbness with severe peripheral neuropathy in his arms, hands and feet. He has no history of stroke. He does have known ataxia with gait abnormalities. He does experience falls frequently. The patient has not had access to a wheelchair since he received his four-wheeler last summer. He has been ambulating at home with a walker.

HEMATOLOGIC: Home care documented hemoglobin of 8.4 and INR of 3.5 yesterday. The patient's Coumadin was held last night.

PHYSICAL EXAMINATION:

GENERAL: The patient is a conversant 72-year-old white male who is oriented to person, place and time and states that he will recline throughout the interview because he is feeling tired. During the interview, the patient consumes two little Debbie cakes and a tootsie roll pop.

HEENT: Head: There is a 2 cm. area of induration at the vertex of the patient's scalp. There is no purulence draining from this site. 1 mm. incision in the center of this lesion is scabbed. The head is atraumatic and normocephalic. Eyes: The patient's pupils are equally round and reactive to light and accommodation.

Extraocular muscles are intact. Non-icteric sclerae. Conjunctivae are pale, pink and moist. Nose negative rhinorrhea. Pink nasal turbinates. Throat: The patient is able to speak clearly and swallow his saliva. There is negative erythema, negative exudate of the posterior oropharynx. Mouth: The patient is edentulous and wearing maxillary and mandibular dentures.

NECK: Supple. There is negative carotid bruit auscultated bilaterally. Negative lymphadenopathy. Negative thyromegaly. Negative jugular venous distention.

HEART: Irregularly irregular. Valve click is present. There is a 3 out of 6 systolic ejection murmur.

LUNGS: Good inspiratory effort, symmetrical diaphragmatic excursion, decreased breath sounds in the apices bilaterally. Wheezes auscultated in the right lower lobe.

ABDOMEN: Protuberant. There are positive active bowel sounds. There is negative palpable pulsatile mass. Negative bruits auscultated. Negative hepatosplenomegaly. Negative hepatjugular reflux. There is tenderness to light palpation of the left supraumbilical region. Negative peritoneal sign.

RECTAL: There are two hemorrhoids protruding exterior to the anal sphincter. These measure 1 inch x 3 mm. No active bleeding is noted at this time.

EXTREMITIES: 4+ pitting edema of the right lower extremity. 3+ pitting edema of the left lower extremity. Dorsalis pedis, peroneal artery and posterior tibialis pulses are non-palpable. Proprioception is intact. Sharp dull discrimination. Hot cold discrimination and vibratory sensation are lacking to the level of the knee.

MUSCULOSKELETAL: The patient experiences bilateral foot drag during his gait. He relies on the assistance of both his walker and his daughter.

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

SKIN: There are multiple ecchymotic lesions on the patient's upper and lower extremities.

GU: Exam deferred to primary care physician.

RECTAL: Exam deferred to primary care physician.

OSTEOPATHIC EXAM: Please refer to attached form.

IMPRESSION:

1. Weakness, worsening.
2. Confusion, new onset.
3. Polychezia, new onset.
4. Status post recurrent GI bleed due to small bowel AVM.
5. Anemia secondary to #4.
6. Diabetes mellitus 2.
7. COPD with pneumoconiosis.
8. Cor pulmonale.
9. Hypothyroidism.
10. Renal insufficiency.
11. History of diastolic CHF.
12. Prosthetic heart valve.
13. Therapeutic anticoagulation for #12.
14. MRSA positive surgical incision.

PLAN:

The patient is being admitted as an in-patient to Dr. Lynn Smith. His vitals and pulse oximetry will be taken routinely. His activity will be restricted to ambulation only with assistance due to his fall risk. Physical Therapy will ambulate the patient three times daily. His diet will be soft mechanical with ground meats. 1800 calorie ADA, ins and outs will be routine. Will be typed and screened. Fingerstick blood glucoses with meds. Fecal occult blood testing stools times three, bedside toilet, diapers, hep-lock port-A-Catheter, CBC and Complete Metabolic Panel now, haptoglobin, LDH levels, daily PT, INR, incentive spirometry every 2 hours while awake, TED stockings if available, otherwise compression stockings, skin precautions for positive MRSA. Medications will include Demadex, 100 mg. PO b.i.d.; Digoxin, 0.125 mg. PO q h.s.; Novolog, 70/30, 20 units subcu daily at 7:30 a.m.; Necon, 1/50 tablet PO b.i.d., Acetaminophen, 50 mg. PO q6 hours p.r.n. for fever or pain, Albuterol Sulfate, 2.5 mg./0.5 ml. neb as directed, Nexium, 20 mg. PO b.i.d., Levoxine, 225 mcg. PO daily at 10:00 a.m., Allopurinol, 300 mg. PO daily at 10:00 a.m., Flomax, 0.4 mg. PO b.i.d., Coumadin, 3 mg. PO daily at 9:00 p.m., hold if INR is greater than 3, Insulin Glargine, 100 units/ml., 35 units subq every evening, Ferrous Sulfate, 325 mg. PO t.i.d., Spironolactone, 100 mg. PO b.i.d., Calcium Citrate, 500 mg. PO q.i.d., O2, 3 liter nasal cannula, Atrovent, 0.5/2.5 mg. nebulizer as directed, Lexapro, 10 mg. PO q h.s., Ativan, 0.5 mg. PO at bedtime,

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Bactrim, 80/400 mg. PO b.i.d., Neomycin, 0.05% Cream topically to scalp t.i.d. times 7 days, orthostatic blood pressures. A transfusion form will be completed. Results for previous PTH, calcitonin levels will be investigated.

Lynn N. Smith, M.D.

Dictated by R. Lagos, D.O., Intern

D: 07/22/08 1604
T: 07/22/08 1635
MAF
PMT, Inc. #20804

REVISED REPORT 07/08/08 1800
DAS
PMT, Inc. Job #: 22958

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: DR. Lynn N. Smith

DATE: 06/26/08

SUBJECTIVE: Mr. Fitzwater is doing a little better. He is up and ambulating. He is getting a little better strength. He is not having as much shortness of breath or weakness. His edema seems to have improved some. The thigh edema is down and he just has the significant edema in his legs so he feels like he is gaining some progress there.

OBJECTIVE: Blood pressure 106/70 with pulse 80, respiration 18. He does have his rash on his neck consistent with a "picker's disease". He has been seen by dermatology services. His lungs show decreased breath sounds in his right base. Cardiac shows his valve clicking murmur which is unchanged. He does have 2+ pitting edema of his legs but it is mostly distally now. There is no open areas and no weeping areas at this time.

His labs show that his BUN is 72, creatinine 2.2 which is stable. His hemoglobin only came up to 9.4 after transfusions again. He has now received a total of 5 units and has a hemoglobin of 9.5. Other electrolytes at this time are acceptable.

IMPRESSION:

1. Recurrent GI bleed secondary to small bowel AVM's.
2. Cor pulmonalia.
3. Valvular heart disease.
4. Diabetes mellitus.
5. Chronic skin rash.

PLAN: We are going to monitor his H&H and electrolytes over the next 24 hours. We will try to contact his gastroenterologist to see what they may have to recommend. This gentleman has had 8 units of blood really over the last 2-3 weeks and obviously is still losing it at a faster rate than what we seem to be controlling it. The questions is whether they can perhaps do some kind of small bowel study on him again for bleeding issues. We will do a bleeding scan and see if we can localize the source of his blood loss.

Lynn N. Smith, M.D.

D: 06/26/08 0736

T: 06/26/08 0752

BJH

cc:

PMT, Inc. Job #: 14134

Dictating Physician's copy / STATUS: Draft

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L
UNIT #: D000038770
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DOB: 04/25/36

DATE: 06/25/08 at 0730

LOCATION: Third floor.

SUBJECTIVE: Mr. Fitzwater feels better this morning. He has less shortness of breath and fatigue. He has been transfused but his hemoglobin has only come up to 8.3. The question is to whether that is just has not equilibrated or that is consistent with him loosing more blood in the interim. He was given some Vitamin K today yesterday because his INR was 5 and now is down to 2.4 this morning. He does not have any new symptoms or complaints.

OBJECTIVE: He has better color today. His lungs show decreased breath sounds at his bases. Cardiac shows his irregular rhythm with this murmur that is unchanged. Abdomen is soft. He has still 2 to 3 + pitting edema bilaterally. No open areas or weeping areas at this time.

IMPRESSION:

1. GI blood loss secondary to small bowel AVM's.
2. Anemia acute on chronic.
3. Cor Pulmonale.
4. Diabetes.
5. Renal insufficiency.

PLAN:

1. We are going to transfuse two more units at this time and monitor his H & H.
2. He will restart on his Warfarin this morning.
3. We will get dermatology to see him because of the rash on his neck and scalp.
4. He will be continued with diuresis for his Cor Pulmonale at this time.

Lynn N. Smith, M.D.

D: 06/25/08 0745

T: 06/25/08 0918

MKM

CC:

PMT, Inc. Job #: 13903

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 06/24/08

DISCHARGE DATE:

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSES:

1. Recurrent gastrointestinal bleed believed secondary to small bowel AVM's.
2. Anemia secondary to #1.
3. Diabetes.
4. Chronic obstructive pulmonary disease with pneumoconiosis.
5. Cor pulmonale.
6. Hypothyroidism.
7. History of congestive heart failure, diastolic.
8. Renal insufficiency.

DISPOSITION: The patient is being transferred to the services of Dr. Joe White, Department of Gastroenterology at CAMC for both, EGD and colonoscopy and hopefully cauterization of AVM's.

SUMMARY: This is a 72 year old gentleman who has a history of small bowel AVM's in the past with recurrent GI bleeding. He had been doing well over the last several months but over the last 2 to 3 weeks had been having increasing blood loss with increasing need for transfusions. He presents to the hospital with increasing weakness, had a hemoglobin of 7.1 and a crit of 19, his platelet count was 329, white count was normal at 12. His INR was slightly up at 5, however, had been well controlled up until recently. He still had heme positive stools. His BUN was 72 with a creatinine of 2.3.

He was hospitalized, was given a total of five units of transfusion with a resultant hemoglobin of 9.5. He felt much better, blood pressures stabilized. We tried to diurese him some and his creatinine remained good at 2, BUN was in the 60's and his sodium did drop some after his bowel prep into the 120's. His calcium was slightly low at 6.8 but corrected to 7.6 with his protein. Mr. Fitzwater actually felt well, he felt much better, he was able to walk with physical therapy, shortness of breath improved, he had no abdominal pain. We did do a bleeding scan because of the amount of blood loss that we had. Unfortunately, this did not reveal anything in particular. We discontinued his Warfarin and his INR was subtherapeutic at 1.5. We did not restart his Warfarin since plans were for a EGD and colonoscopy on Monday. We placed him on Lovenox, 1 mg per kg subcu twice daily. He, at this time, is feeling much better, does not have any major complaints and plans are for him to go to Charleston for an EGD and colonoscopy to try to ascertain the source of bleeding.

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 06/24/08

DISCHARGE DATE:

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

Copies of his labs and dictation will go with the patient. His current med list will be sent as well.

Lynn N. Smith, M.D.

D: 06/30/08 0736

T: 06/30/08 0745

VMN

PMT, Inc., Job #14983

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.313

UNIT #: D000038776

ADMISSION DATE: 06/24/08

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY OF PRESENT ILLNESS: This is a 72-year-old male who presents with chief complaint of hemoglobin 7.4 yesterday per Home Health. He states that he has had increased dizziness and weakness times two days. He also complains of increased shortness of breath. He denies any chest pain. He states that he has a 15-pound weight gain over the past one week and has to sleep propped up. He states that he has had some increased peripheral edema as well. He has continued his home medications and not noticed any visible blood loss. States that he does take iron pills though it is difficult for him to determine whether or not he is losing any blood. Mr. Fitzwater has known small bowel AVM's and these tend to be the source of his anemia. He is normally followed in Charleston and is scheduled to return there for evaluation by the gastroenterologist in September.

PAST MEDICAL HISTORY: Positive for valvular heart disease, status post aortic valve replacement, history of restrictive pericarditis, Type 2 diabetes, COPD with pneumoconiosis, CHF, recurrent GI bleed secondary to AVM, mild renal insufficiency, history of chronic A-fib, multiple episodes of toxic shock syndrome, hypothyroidism.

MEDICATIONS:

Lexapro, 10 mg. at bedtime.
Nexium, 20 mg. b.i.d.
Flomax, 0.4 mg. b.i.d.
Demadex, 100 mg. b.i.d.
Aldactone, 100 mg. b.i.d.
Synthroid, 222 mg. daily.
Allopurinol, 300 mg. daily.
Lanoxin, 0.125 mg. at bedtime.
Iron tablets 3 times daily.
Novolog, 70/30, 20 units in the a.m.
Lantus, 35 units at bedtime.
Albuterol and Atrovent nebs.
Necon, 1/35, 1/50 b.i.d.

ALLERGIES: No known drug allergies.

PAST SURGICAL HISTORY: Positive for permanent pacer placement, pericardial stripping, cholecystectomy, appendectomy, TUR by microwave, aortic valve replacement with prosthetic mechanical valve, circumcision.

SOCIAL HISTORY: The patient is a retired coal miner. He lives at home with his wife. He has a longstanding history of smoking but has not smoked for several months. He denies any alcohol.

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

FAMILY HISTORY: Positive for diabetes, heart disease and premature coronary disease.

REVIEW OF SYSTEMS: The patient denies any headache or nosebleed. Does complain of some dizziness and weakness over the past two days. States he does have some difficulty swallowing meats and has to have them chopped. Denies any chest pain. Does complain of the above-noted shortness of breath. Denies any abdominal pain, nausea, vomiting, diarrhea or constipation. Denies any urinary complaints. Denies any unusual rashes, bleeding or bruising. Denies any numbness or tingling in his extremities. Denies any fever, sweats or chills. Does complain of a 15-pound weight gain over the past one week. Complains of the above-noted increased edema in his extremities. States this mood has been stable.

OBJECTIVE: Vital signs: Blood pressure 135/74; pulse 99; respirations 26; temp 97.9.

GENERAL: 72-year-old male who is alert and oriented, answers questions appropriately. He is in no acute distress.

HEENT: Head is atraumatic, normocephalic. Eyes: PERRLA. EOMI. External auditory canals are clear bilaterally. Tympanic membranes are pearly gray, intact bilaterally. Nasal mucosa is moist and pink. Posterior oropharynx is moist and pink.

NECK: Supple without lymphadenopathy, thyromegaly, JVD or carotid bruits.

HEART: Irregularly irregular.

LUNGS: Diminished breath sounds at the bases.

ABDOMEN: Obese with positive bowel sounds, non-tender. Abdomen is mildly distended.

EXTREMITIES: Peripheral pulses are +2/4 bilaterally for upper extremities and a faint +1/4 bilaterally for the lower extremities. There is 3+ pitting edema bilaterally in the lower extremities.

NEUROLOGIC: Affect is appropriate. Neurologic exam is afocal.

RECTAL: Deferred to primary care.

GENITAL: Deferred to primary care.

INVESTIGATIONS: CBC white count 12.6; hemoglobin 7.1; hematocrit 19.8; platelets 329. PT 46.3. INR 5.04. BMP sodium 130; potassium 4.6; chloride 95; CO2 25.7. BUN 72. Creatinine 2.3. Glucose 244. Calcium 6.4 which corrected to 7.3. Estimated GFR is 29. Albumin 2.9.

ASSESSMENT:

1. Anemia secondary to small bowel AVM.
2. Elevated INR.
3. Diabetes.
4. COPD with pneumoconiosis.
5. Hypothyroidism.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

6. Congestive heart failure.

PLAN:

The patient will be placed in observation service, Dr. Smith. Will continue his home medicine and transfuse 3 units of packed red blood cells. Will monitor his H&H. Will place him on an 1800 calorie ADA 4 gram sodium diet. PTH is pending at this time. Will give him additional diuresis with Lasix. Will give him Vitamin-K secondary to his elevated INR. The patient has been discussed with Dr. Smith. Please see the orders for details.

Lynn N. Smith, M.D.

Dictated by S. Myles, D.O.

D: 06/24/08 0952
T: 06/24/08 1009
MAF
PMT, Inc. #13689
CC:

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.304 UNIT #: D000038770
ADMISSION DATE: 06/05/08
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: This is a 72 year old with multi-system. He presented to the office with increasing shortness of breath, weakness and increasing weeping from his legs. He has known recurrent GI bleeds due to AV malformations and is usually hospitalized for five-unit transfusion. He also has known severe pulmonary hypertension and cor pulmonale and history of congestive heart failure. He had increasing shortness of breath and weakness to the point that he was unable to get up and ambulate. He is extremely weak with over congestive failure and edema at this time. He is being admitted to the hospital for more aggressive management.

PAST MEDICAL HISTORY: He has history of valvular heart disease, status post aortic valve replacement. He has had an episode of restrictive pericarditis. He is a Type 2 diabetic. He has known COPD with pneumoconiosis, history of congestive heart failure, recurrent GI bleeds due to AVM, mild renal insufficiency. He has a history of chronic atrial fibrillation and has had several episodes of toxic shock syndrome, hypothyroidism.

PAST SURGICAL HISTORY: He has had a permanent pacemaker, pericardial stripping. He has also had a cholecystectomy, appendectomy and TUR by microwave. He has had an aortic valve replacement. He has a prosthetic mechanical valve. He has also had a circumcision.

ALLERGIES: None.

CURRENT MEDICATIONS: Numerous which include Allopurinol, Nexium, Flomax, Aldactone, Lasix, Synthroid, Lanoxin, Glyburide, Reglan, Warfarin. He is also on iron replacement therapy.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He has a longstanding history of cigarettes but has not smoked now for a number of months. No significant alcohol.

FAMILY HISTORY: Positive for both diabetes, heart disease and premature coronary disease.

REVIEW OF SYSTEMS: His weight is up about 10 pounds, he says. He has glasses. Has no difficulty in hearing. He has no difficulty in swallowing. Skin: Chronic changes with chronic dermatitis at his legs and multiple ecchymotic areas due to his chronic anticoagulation. Cardiac: He has some palpitations. No chest pains or palpitations. No PND. He does have shortness of breath. Respiratory: Cough with occasional wheeze. No mucus or sputum. GI: No nausea, vomiting or diarrhea. GU: No dysuria, frequency or hesitancy. Musculoskeletal: He has severe back and hip pain. He has advanced osteoarthritis and is really not a candidate for anything else.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

to be done to his knees and hips according to Orthopedics. He has noted some marked increase in edema over the last several days. Neurologically he has been alert and oriented. No focal neurologic change. He has difficulty with ambulation because of some weakness issues. He has had no syncope. He has gait disturbances and history of ataxia.

PHYSICAL EXAMINATION: He is awake. He is alert. He is in moderate respiratory distress. Blood pressure 153/80 with pulse that is 80; respirations 22.
SKIN: Multiple ecchymotic areas. His legs are grossly edematous with weeping in the right lower extremity.
HEENT: Pupils are equal and reactive. He is pale. Posterior pharynx is clear.
NECK: Minimal bruit on the right.
LUNGS: He has decreased breath sounds in both lungs with rales.
HEART: He has a valve click with no diastolic murmur. He is in atrial fib with controlled rate.
ABDOMEN: Obese. Bowel sounds are active. I cannot feel any organomegaly or tenderness at this time.

EXTREMITIES: As described with no palpable peripheral pulses.
NEUROLOGICAL: He is alert and oriented, moves all extremities. At this time does not have any focal neurological change.

IMPRESSION:

1. Progressive anemia with recurrent GI bleeds.
2. Cor pulmonale.
3. Pulmonary hypertension.
4. Prosthetic valve.
5. Diabetes mellitus.
6. Hypothyroidism.
7. COPD.
8. BPH.

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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN:

Will admit him at this time. His labs will be drawn. Probable transfusion. He will be more aggressively diuresed and will have to monitor his renal function at this time. Long-term prognosis is poor.

Lynn N. Smith, M.D.

D: 06/06/08 0741
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MAF
PMT, Inc. #09996
CC:

**Lynn Smith, MD
Valley Medical Associates
Route 2 Box 171
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304-645-3207
OFFICE NOTE**

PATIENT NAME: Fitzwater Jackie

ACCOUNT #: 001502

DATE: 9/25/2007

CHIEF COMPLAINT: Patient returns today for his follow up. Patient is doing well at this time.

HISTORY: Patient comes back in for his routine follow-up. Over the last month or so he's been doing quite well. His hemoglobin has remained stable. He's had no major heart failure promises weight has been good. He's eating a lot more and like to see but he seems to be doing fairly well with a sugar control as well.

MEDICATIONS: , Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Demadex 100 mg p.o. b.i.d., Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 5 mg daily. Aldactone 100 mg b.i.d. Chantix 1 mg b.i.d.

ALLERGY: None

SOCIAL HISTORY: Patient says he has not smoked any cigarettes since he stopped after his last hospitalization

PHYSICAL EXAM: VITAL SIGNS weight 206.5 pounds, BP 124/68, pulse 80

GENERAL: Alert and in no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. Dentition adequate. He has no pallor to his conjunctiva this time.

NECK: Supple. Trachea midline. No masses or thyromegly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. . His mouth click in his aortic region is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base are noted consistent with his chronic effusion. **ABDOMEN:** Abdomen is protuberant bowel sounds are normal active. No fluid wave is noted swelling is much less than when he was recently hospitalized.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. There is one plus pitting edema at this time bilaterally. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM

2. Valvular heart disease status post aortic valve replacement

3. Severe cor pulmonale
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will continue with his current monitoring. His protime will be drawn in two weeks. His CBC and BMP will be drawn on a monthly basis. Have asked him to return in one month for follow-up. Flu shot will be due at that time.

Lynn N. Smith M.D.

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OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 8/23/2007
ACCOUNT NO. 001502

VITAL SIGNS: Wt. 103.7 pounds, BP 116/64, pulse 88

History: Patient back in today for his follow-up. He has done better. We did start him on the birth control pills for his small bowel AVMs. His hemoglobin has remained stable in the 10.4 range. He still having quite a bit of weakness. Part of this is just quad weakness due to inactivity. His pro time was elevated at 5.1 48 hours ago. We held his Coumadin for two days. Today in the opposite is registering as a 1.5 INR. I don't believe that is possible. One or the other has to be in error. He has not had any significant bleeding. He's not had any swelling. He's actually been feeling better otherwise.

REVIEW OF SYSTEMS: Appetite and weight is stable. No chest pains or palpitations. Edema has been under good control. He has not had any change in bowel habits. No breast tenderness. Shortness of breath has been stable-he's not using his oxygen on a regular basis.

Social History: Patient has remained off of cigarettes at this time. He is still using Chantix.

Physical Exam: HEENT is unremarkable. Lungs show decreased breath sounds at the right base. Cardiac shows irregular rhythm with his valve click. No diastolic murmur. Abdomen is obese, bowel sounds are active. His edema looks much better and his chronic stasis dermatitis is much better. He does have some burning dysesthesias of his feet with known severe neuropathy. He has been off of his Neurontin now for some time. He is ambulatory with some difficulty. He will use his walker on a regular basis.

ASSESSMENT: Recurrent GI bleed secondary to small bowel AVM. Cor pulmonale. Renal insufficiency. Diabetes mellitus. Peripheral neuropathy.

PLAN: We will get a protime drawn today at the hospital and determine how to restart his warfarin. He will go back on his Neurontin 400 mg twice a day. This is to be used for his neuropathy. We will continue monitoring his H&H every two weeks. New prescription for B12 injections and for Nasacort AQ given today. Follow up appointment in one month.

Lynn N. Smith M.D.

Lynn Smith, MD
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Route 2 Box 171
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304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie

ACCOUNT #: 001502

DATE: 7/30/2007

CHIEF COMPLAINT: Patient returns today for his follow up. Patient was recent hospitalized due to worsening right-sided failure and edema..

HISTORY: Mr. Fitzwater was recently hospitalized with increasing edema and ascites. His workup showed that this was just consistent with his right-sided failure. He had no evidence of DVT. No change in his cor pulmonale. And changed his pulmonary hypertension. Adjustments were made in his medication and he's lost about 13 pounds since going home. He still having some fatigue issues but his shortness of breath has significantly improved

MEDICATIONS: , Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Demadex 100 mg p.o. b.i.d., Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 6 mg daily. Contact home under milligrams p.o. b.i.d.

ALLERGY: None

SOCIAL HISTORY: Patient says he has not smoked any cigarettes since he stopped after his last hospitalization.

PHYSICAL EXAM: VITAL SIGNS weight 205.9 pounds BP

128/50, pulse 96

GENERAL: Alert and in

no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. Dentition adequate. He has no pallor to his conjunctiva this time.

NECK: Supple. Trachea midline. No masses or thyromegly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. , . His mouth click in his aortic region is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base are noted consistent with his chronic effusion. **ABDOMEN:** Abdomen is protuberant bowel sounds are normal active. No fluid wave is noted swelling is much less than when he was recently hospitalized.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. There is no significant edema at this time. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM

2. Valvular heart disease status post aortic valve replacement

3. Severe cor pulmonale
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will have his CBC, basic metabolic panel and pro time drawn on Thursday. Will continue monitoring his weight in his intake. A letter will be see to his insurance carrier to see if we can get his birth control pills authorized. He will have a follow up in two weeks.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
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OFFICE NOTE

PATIENT NAME: Fitzwater, Jackie
DATE: 7/5/2007
ACCOUNT NO. 001502

VITAL SIGNS: Wt. 218.6 pounds, BP 122/72, pulse 92

History: Patient in today on sick call. He said nausea and vomiting over the last 24 hours. Marked increase in weight with increasing shortness of breath. He show signs of overt failure with increasing edema. He is being admitted to the hospital this time for further aggressive therapy.

Lynn N. Smith M.D.

Lynn Smith, MD
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OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
ACCOUNT #: 001502
DATE: 6/17/2007

CHIEF COMPLAINT: Patient returns today for his follow up. Patient was recent hospitalized and transfused due to a recurrent anemia.

HISTORY: Patient had been started back on his warfarin and obtain therapeutic levels. He was recent hospitalized because of his progressive anemia and received two units of blood for transfusion. He has not noticed any recurrent bleeding. He exactly felt well and is active level has done well over the last week. His last INR was still elevated at 3.71 warfarin 6 mg daily. He has noted some slight increasing edema since his discharge.

MEDICATIONS: , Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Lasix 120 mg p.o. b.i.d., Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 6 mg daily. Zaroxolyn 5 mg twice weekly

ALLERGY: None

SOCIAL HISTORY: Patient has been a smoker of at least a pack a day. He stopped 10 days ago when hospitalized. He is still using the Chantix at this time to keep him off the cigarettes. He has been able to remain off cigarettes since his discharge.

PHYSICAL EXAM: VITAL SIGNS -weight 221.8 pounds, BP 112/62, pulse 96 GENERAL: Alert and in no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. Dentition adequate. He has no pallor to his conjunctiva this time.

NECK: Supple. Trachea midline. No masses or thyromegly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. . His mouth click in his aortic region is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base are noted consistent with his chronic effusion. **ABDOMEN:** Abdomen is protuberant bowel sounds are normal active. No fluid wave is noted.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. Patient has some edema of his legs however much of this appears to be above his knees. There is still at least one plus pitting edema distally.. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

Laboratory: Current INR today is 4.0. Recent lab showed creatinine at 1.8 and elevated aldosterone level at 20.6

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM
2. Valvular heart disease status post aortic valve replacement
3. Diabetes mellitus
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will hold his warfarin for two days. He will resume 5 mg daily. A repeat protime will be drawn on Thursday. He is to restart Aldactone 50 mg daily. We will have a repeat of his electrolytes on Thursday when he is due for his next protime to be checked. He will have her return appointment in two weeks.


Lynn N. Smith M.D.

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304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie

ACCOUNT #: 001502

DATE: 6/17/2007

CHIEF COMPLAINT: Patient returns today for his follow up. He's actually been doing pretty well, and has felt well during the last couple weeks.

HISTORY: Overall for the past couple weeks he has been able to come off of his Lovenox and continue with his warfarin. His appetite has been good in his functional level is improved. He just did complete his capsule endoscopy in Charleston. The it will probably be two weeks before we have that result. He is still getting his weekly CBCs and there due to be drawn tomorrow. He has noted some increased swelling. We did start him back on his Lasix and he's been taking his Zaroxolyn once or twice a week. His weight however has gradually increased since coming out of the hospital.

MEDICATIONS: , Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Lasix 120 mg p.o. b.i.d., Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 7 mg daily. Zaroxolyn 5 mg twice weekly

ALLERGY: None

SOCIAL HISTORY: Patient has been a smoker of at least a pack a day. He stopped 10 days ago when hospitalized. He is still using the Chantix at this time to keep him off the cigarettes.

PHYSICAL EXAM: VITAL SIGNS - weight not recorded today, BP 128/60, pulse 72

GENERAL: Alert and in no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. Dentition adequate. He has no pallor to his conjunctiva this time.

NECK: Supple. Trachea midline. No masses or thyromegaly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. . His mouth click in his aortic region is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base are noted consistent with his chronic effusion. **ABDOMEN:** Abdomen is protuberant bowel sounds are normal active.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. Two plus edema is noted bilaterally. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

Pro time today shows an INR of 3.5.

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM
2. Valvular heart disease status post aortic valve replacement
3. Diabetes mellitus
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will decrease his warfarin 6 mg alternating 7.5 mg daily. He will continue with his current other medical regimen. A CBC, BMP, aldosterone level was drawn tomorrow by home health nurses. Follow up in two weeks. Continue monitoring his daily weights.

Lynn N. Smith M.D.



**Lynn Smith, MD
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Route 2 Box 171
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304-645-3207
OFFICE NOTE**

PATIENT NAME: Fitzwater Jackie
ACCOUNT #: 001502
DATE: 6/7/2007

CHIEF COMPLAINT: Patient returns today after hospitalization in Charleston for recurrent GI bleeding.

HISTORY: This 71 year-old has known recurrent GI bleeds to the small bowel AVMs. He has significant pulmonary hypertension and cor pulmonale. He was sent to Charleston having acute bleed with a hemoglobin of approximately 8. They did find two AVMs that were cauterized. He is scheduled to go back to have a capsule endoscopy performed and possible further cauterization. He is feeling better since going home. He has had significant increase in edema due to some changes in his medication.

MEDICATIONS: Lovenox 90 mg daily, Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Lasix 80 mg daily, Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 6 mg daily.

ALLERGY: None

SOCIAL HISTORY: Patient has been a smoker of at least a pack a day. He stopped 10 days ago when hospitalized.

PHYSICAL EXAM: VITAL SIGNS - weight 210 pounds, BP 118/60, pulse 88

GENERAL: Alert and in no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. Dentition adequate.

NECK: Supple. Trachea midline. No masses or thyromegly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. . His mouth click in his aortic region is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base are noted consistent with his chronic effusion. **ABDOMEN:** Abdomen is protuberant bowel sounds are normal active.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. Two to three plus edema is noted bilaterally. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal lymphadenopathy.

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM

2. Valvular heart disease status post aortic valve replacement
3. Diabetes mellitus
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will have a CBC and BMP drawn today. He will increase his Lasix to 120 mg b.i.d. Warfarin will increase to 7 mg daily. We will discuss the possible need to increase his Lovenox dose after we see is currently labs. Follow up in one week.


Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: July 18, 2008
ACCOUNT NO. 001502

CC: Follow-up

VITAL SIGNS: Wt. 213.4 pounds, BP 122/82, pulse 84

History: Patient is in today for follow. He was hospitalized last week because of his progressive anemia. He was transfused another three units of packed cells. His resulting hemoglobin was 9.5. His hemoglobin yesterday shows the level has decreased to 8.7 g. He is just not doing well. He's having more difficulty with ambulation and increased swelling. We did have him on his Zaroxolyn therapy for a few days which did help some. His INR has been therapeutic at 2.56. He's developed a significant pain and swelling on his scalp. He's had a history of some recurrent abscesses.

MEDS: Nexium 40 mg daily, torsemide 100 mg b.i.d., iron 324 mg t.i.d., levothyroid .25 mg daily, allopurinol 300 mg daily, Lanoxin .125 mg daily, Flomax .4 mg daily, Aldactone 100 mg b.i.d., warfarin 4 mg daily, NovoLog 5 units with meals, Lantus 25 mg in evening.

REVIEW OF SYSTEMS: Patient denies any fevers, chills or sweats.

Cardiac: There is no history of any significant chest pain, palpitations, PND or orthopnea.

Pulmonary: There is no history of significant cough or sputum production. He still does have significant shortness of breath with activity.

GI: There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding.

GU: There is no history of any dysuria or frequency.

MS: There has been no significant change in musculoskeletal complaints. Patient requires a walker for ambulation. His balance is still severely abnormal as well as his motor strength.

Physical Exam: There is an abscess present on the top of his head. It is very fluctuant. Lung fields shows decreased breath sounds at the right base. Cardiac shows his valve click with no new murmurs. He does have 2-3 plus pitting edema. He is alert and oriented does not appear to be in any distress.

ASSESSMENT: Scalp abscess. Recurrent GI bleed secondary to AV malformations. Mechanical aortic prosthetic valve. Cor pulmonale. Diabetes mellitus. COPD. BPH with known bladder outlet symptoms. Anemia secondary to recurrent blood loss

PLAN: We have done an I&D of the abscess and drained it at this time. He will be started on Bactrim one tablet twice daily. He will stay on his Zaroxolyn. He will most likely need a transfusion the first of the week. He will have a repeat of his labs drawn at that time. Cultures sent

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 6/5/2008
ACCOUNT NO: 001502

CC. Patient comes in for one week follow-up.

Vital Signs: Wt. 208.8 pounds, BP 150/64, pulse 100

History: Patient is back in today for his follow-up. He had transfusions obtained last week because of his anemia. He has continued to have significant increased weight and swelling. He's had weeping from his legs predominantly on the right recently.

Physical Exam: Patient is extremely weak. He has moderate dyspnea with the surgeon. He does appear to be pale. His extremities show significant bilateral edema with weeping findings on his right lower extremity.

ASSESSMENT: Recurrent GI bleed secondary to AV malformation. Anemia. Cor pulmonale with significant right-sided failure.

PLAN: Patient will be admitted at this time for further treatment and evaluation.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 5/29/2008
ACCOUNT NO. 001502

CC: Edema

VITAL SIGNS: Wt. 207.2 pounds, BP 142/62, pulse 88

History: Patient is in today for follow. He was hospitalized last week because of his progressive anemia. He was transfused a total of five units of packed cells. His repeat H&H this morning is now 10.3. His INR is therapeutic at 3.2. He has had a significant increase in edema associated with his transfusions. He has been taking both his Aldactone and his Zaroxolyn over the last three days. He states that his weight has improved, but he still obvious the caring more fluid than normal.

MEDS: Nexium 40 mg daily, torsemide 100 mg b.i.d., iron 324 mg t.i.d., Luvox and .25 mg daily, allopurinol 300 mg daily, Lanoxin .125 mg daily, Flomax .4 mg daily, Aldactone 100 mg b.i.d., warfarin 4 mg daily, NovoLog 5 units with meals, Lantus 25 mg in evening.

REVIEW OF SYSTEMS: Patient denies any fevers, chills or sweats.

Cardiac: There is no history of any significant chest pain, palpitations, PND or orthopnea.

Pulmonary: There is no history of significant cough or sputum production. He still does have significant shortness of breath with activity.

GI: There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding.

GU: There is no history of any dysuria or frequency.

MS: There has been no significant change in musculoskeletal complaints. Patient requires a walker for ambulation. His balance is still severely abnormal as well as his motor strength.

Physical Exam: HEENT is unchanged. He does have some dullness in his right base which is chronic. Cardiac shows his regular rhythm with a valve click. Abdomen is obese. He has two plus pitting edema bilaterally. Chronic trophic changes are noted in his legs. He is walking with a walker at this time.

ASSESSMENT: Recurrent GI bleed secondary to AV malformations. Mechanical aortic prosthetic valve. Cor-pulmonale. Diabetes mellitus. COPD. BPH with known bladder outlet symptoms

PLAN: Patient will be sent to the hospital for a BMP and urine for sodium and potassium. He will return in approximately 1 hour for a post voiding bladder study. We will then be able to make some decisions as to whether this gentleman needs further adjustments of his medication.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 5/6/2008
ACCOUNT NO. 001502

CC: Follow-up appointment/weakness

VITAL SIGNS: Wt. 205.6 pounds, BP 136/62, pulse 76

History: Patient is in today for his routine follow-up. He has noted some increasing weakness and shortness of breath. This has been much worse over the last two to three days. He's not had any chest pain. He's not seen any active change in his GI blood loss. Appetite has remained good. He has become less functional because of his symptoms.

Social history: Patient denies any cigarette use at this time. He denies any alcohol use. He is getting very unlimited activity because of his mobility issues.

REVIEW OF SYSTEMS: Patient denies any fevers, chills or sweats.

Cardiac: There is no history of any significant chest pain, palpitations, PND or orthopnea.

Pulmonary: There is no history of significant cough or sputum production. Marked increased dyspnea has been noted. There has been some increasing peripheral edema.

GI: There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding.

GU: There is no history of any dysuria or frequency.

MS: There has been no significant change in musculoskeletal complaints. Patient just saw orthopedics today and had an injection in the right knee because of his advanced arthritis. They basically told him because of his multiple health problems, he would not be a candidate for joint replacement.

Physical Exam: Patient is extremely pale. No scleral icterus. Lungs show decreased breath sounds at the right. Cardiac shows regular rhythm with his valve click. No new diastolic murmurs audible. Abdomen is obese with normal bowel sounds. He does have one plus pitting edema. Chronic skin changes are noted.

Laboratory: Hemoglobin is now down to 7.6. INR is therapeutic at 2.7.

ASSESSMENT: ~~Progressive anemia secondary to GI blood loss. Chronic GI blood loss secondary to~~
small bowel AV malformations. Mechanical prosthetic valve. Cor pulmonale. Diabetes mellitus.
COPD.

PLAN: Patient will be sent at this time to the hospital for transfusion. We will give him three units of blood at this time. He will continue with his other routine medications. We will arrange for home

health to continue monitoring his blood counts on a weekly basis.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 4/21/2008
ACCOUNT NO. 001502

VITAL SIGNS: Wt. 209.4 pounds, BP 132/70, pulse 82

CC: Routine follow-up

History: Patient is in today for his routine follow-up. His most recent labs show that his pro time is therapeutic at 2.63. His hemoglobin is stable at 8.7 g. CBC otherwise is unremarkable. His creatinine is also stable at 2.1. He notices significant increase in edema over the weekend. He was started on one of his Zaroxolyn tablets and is evidently lost 5 pounds in the last day.

Review systems: Skin-patient has recurrent infectious nodules on his scalp and his posterior neck. These are usually excoriated. It have responded nicely to antibiotics in the past, and have been biopsied recently by ENT without evidence of any malignancy. His shortness of breath has been stable. He denies any chest pains or palpitations. He has noted some increased swelling recently. There is no history to any recent falls or injuries.

Physical Exam: Multiple ecchymotic areas are still present on the arms. Lungs show decreased breath sounds at the right base, but are otherwise clear. His cardiac shows an irregular rhythm with his valve click and murmur which is unchanged. No abdominal tenderness is noted. There is two plus pitting edema bilaterally. Patient still is quite ataxic and has to use his walker for assistance.

ASSESSMENT: Diabetes type II. Hyperlipidemia. Status post mechanical prosthetic valve. Folliculitis of the neck. Chronic GI bleed secondary to small bowel AV malformations. Anemia secondary to chronic blood loss.

PLAN: Patient will use his Zaroxolyn daily for the next three days and monitor his weight. At his next blood draw a hemoglobin A1c, TSH and lipid profile will be obtained. He will start on amoxicillin 250 milligrams-three times daily for his folliculitis. He will continue to be monitored for his protime and his anemia.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 4/1/2008
ACCOUNT NO. 001502

VITAL SIGNS: Wt. 208.6 pounds, BP 132/62, pulse 80

History: Patient is back in today for his routine follow-up. Since his last visit he has now gained about 14 pounds. He is having some increasing shortness of breath. His hemoglobin is gradually been dropping with his last one test yesterday down to 8.6 g. He states he has not been smoking, and his physical activity has been somewhat limited. He has not seen any significant bleeding since his previous visits.

Social History: No cigarette use at this time. Patient is going to active physical therapy for his hip and gait management.

REVIEW OF SYSTEMS: <<2>> Patient denies any fevers, chills or sweats.

Cardiac: <<3>> There is no history of any significant chest pain, palpitations, PND or orthopnea. Increase in edema has been noted.

Pulmonary: <<4>> There is no history of significant cough or sputum production.

GI: <<5>> There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding.

GU: <<6>> There is no history of any dysuria or frequency.

MS: <<7>> There has been no significant change in musculoskeletal complaints. No new rashes are identified. Patient still complains of pain in the right hip. He still complains of some discomfort in his calves bilaterally and distally.

Laboratory: INR is therapeutic at 2.8. Hemoglobin is 8.6. Electrolytes are unremarkable to creatinine of 2.1.

Physical Exam: Mild pallor is noted. Lungs show decreased breath sounds at the right base but no evidence of any other rales. Cardiac shows his valve click with his mild systolic murmur. Truncal obesity is noted. Patient does have increasing edema at least 1-2 plus at this time. No breakdown in skin or new rashes are noted on his distal extremities. Patient still has severe peripheral neuropathy findings in his feet bilaterally.

ASSESSMENT: Chronic GI bleed secondary to small bowel AV malformations. Prosthetic valve on chronic anticoagulation. Renal insufficiency. Diabetes mellitus.

PLAN: He will start using his Zaroxolyn 5 mg daily in combination with his diuretics for the next three days. Will monitor his weight. He is due for repeat labs in one week, and he will most likely have to be admitted for hospitalization and transfusion at that time.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207

OFFICE NOTE

PATIENT NAME: Fitzwater Jackie

DATE: 2/28/2008

ACCOUNT NO. 001502

VITAL SIGNS: Wt. 194 pounds, BP 120/58, pulse 84

History: Patient is back in today for follow-up. He was transfused and his last hemoglobin was 9.6. We adjusted his insulin by increasing his Lantus to 35 units at night and his novel and 70/30 to 20 units in the morning. His blood sugars have been doing much better since his adjustments were made. He is running fasting sugars in the 100 to 120 range. Evening sugars are under 200. He states that he feels better. His overall activity is still quite limited because of his recent hip fracture, but he says that he does feel better.

REVIEW OF SYSTEMS: Patient denies any fevers, chills or sweats.

Cardiac: There is no history of any significant chest pain, palpitations, PND or orthopnea.

Pulmonary: There is no history of significant cough or sputum production.

GI: There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding.

GU: There is no history of any dysuria or frequency.

MS: There has been no significant change in musculoskeletal complaints. Patient continues to have some pain in his right hip consistent with his recent hip surgery. There's also tenderness in that right quadriceps and hamstring region, and the patient was told that he had a torn muscle in that region.

Physical Exam: Decreased breath sounds at the right lung. Patient is in atrial fib with controlled rate. Valve click is unchanged. No abdominal tenderness. Trace to one plus edema is noted. Patient walks adequately at this time with a walker.

ASSESSMENT: Status post prosthetic valve. Chronic atrial fibrillation. Status post hip fracture. History of recurrent GI bleed secondary to AV malformation. Anemia secondary to recurrent blood loss. Severe peripheral neuropathy. Diabetes type II-insulin requiring

PLAN: Patient will have a repeat pro time in two weeks and a CBC at that time. He reschedule for a CT of his right thigh to rule out the possibility of a muscle tear.

Lynn N. Smith M.D.

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 19360425

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 02/14/08 at 0730

LOCATION: Third floor.

SUBJECTIVE: Patient did well throughout the night. He slept well. He got his transfusions without complication. Sugars are much better this morning. It is down to 114. His INR has also come down to 3.3 which is back in the therapeutic range. He feels better, less shortness of breath. No significant PND or edema.

OBJECTIVE: BP is 134/70, O2 sat is 98 %. Lungs show some decreased breath sounds in the right which is chronic. Cardiac shows his irregular rhythm with his valve click which is unchanged no abdominal tenderness. He does have about 1 + edema which is chronic for him.

LABORATORY: His hemoglobin has come up to 9.2, otherwise we did prove that is iron levels are back down low again.

IMPRESSION:

1. Recurrent GI bleed secondary to AV malformations.
2. Anemia secondary to blood loss and iron deficiency.
3. Iron deficiency.
4. Prosthetic valve and chronic anticoagulation.
5. Pulmonary hypertension with Cor Pulmonale.
6. COPD.

PLAN:

1. We will plan to discharge him home at this time.
2. We will increase his insulin to 20 units in the morning 35 of Lantus at night.
3. He will start back on his iron therapy.
4. Warfarin has been decreased to 3 mg. alternating with 4 mg.
5. Will have Home Health check him on a weekly basis and will see him in the office in two weeks.

Lynn N. Smith, M.D.

D: 02/14/08 0754

T: 02/14/08 1050

MKM

CC:

PMT, Inc. Job #: 07642

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207

OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 2/13/2008
ACCOUNT NO. 001502


History: Patient is back today for his routine follow-up. His INR was elevated at greater than six yesterday and his Coumadin was put on hold. His hemoglobin is down to 7.3. He has known recurrent bleeding secondary to AV malformations. He has not been on iron therapy since coming out of the nursing home.

Physical Exam: Pallor is noted. Decreased lung sounds are noted. Valve click is unchanged no new murmur.

ASSESSMENT: Recurrent anemia secondary to GI blood loss.

PLAN: Patient is being admitted to observation this time for transfusion. Adjustment of his diabetic therapy.

Lynn N. Smith M.D.



Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 1/23/2008
ACCOUNT NO. 001502

VITAL SIGNS: Wt. 184 pounds. BP 128/58, pulse 72

History: Patient is back in today for follow-up. He suffered a right fractured hip that subsequently was treated at CAMC. He was sent to rehabilitation and has just gotten out within the past week. He has not been very happy because of all the things that transpired at the nursing facility. He actually seems very depressed at this time. He's been very tearful and very intolerant of most things or been going on both at the nursing facility and since has come home. He's not been sleeping well during this time frame. He is ambulating well at this time with use of a walker. He has improved with his quad weakness and gait training.

REVIEW OF SYSTEMS: Patient denies any fevers, chills or sweats.

Cardiac: There is no history of any significant chest pain, palpitations, PND or orthopnea.

Pulmonary: There is no history of significant cough or sputum production. Patient still has significant dyspnea with minimal activity. O2 has been in use on a regular basis.

GI: There is no history of any nausea, vomiting or diarrhea. No evidence of active bleeding. He has recently been hospitalized and received a transfusion because of his persistent microscopic blood loss than his bowel.

GU: There is no history of any dysuria or frequency.

MS: There has been no significant change in musculoskeletal complaints. He still has significant tenderness in his legs and feet. He has been complaining of increased numbness in his hands bilaterally. Prior history of carpal tunnel syndrome with surgical release bilaterally is present. No new rashes are identified.

Social History: Patient states that he has not been smoking since his most recent hospitalization and while in the nursing facility. He is currently off of Chantix at this time.

Physical Exam: HEENT is unremarkable. Lungs show dullness at his right base with a stone chronic effusion. No wheezes are noted. Valve click is unchanged. His systolic ejection murmur still present. No diastolic murmur is noted. Abdomen is obese bowel sounds are active. Extremities show no evidence of pitting edema to this time. Chronic trophic changes distally are noted. He has bilateral Tinel's and Phalen's. Right worse than left. There is some possible atrophy of the thenar eminence in his right hand.

Laboratory: Recent labs drawn just two days ago so that his hemoglobin is stable at 10 g. Creatinine is 2.2 with his bun of 40. Electrolytes are unremarkable. He sugars are still elevated at this time.

ASSESSMENT: Diabetes type II insulin requiring. Pulmonary hypertension with cor pulmonale.

Status post hip fracture. Status post mechanical valve replacement. Chronic peripheral neuropathy. Chronic GI bleed secondary to small bowel AV malformations. New onset depression

PLAN: Patient will continue with his Lantus to 25 units in evening. Will begin Novolin 70/30 12 units in the a.m. He will continue monitoring his sugars fasting and 4 p.m. We will begin him on Lexapro 10 mg in the evening for his depression. Patient will discontinue his glyburide at this time. Return appointment in three weeks.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207

OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 11/20/2007
ACCOUNT NO. 001502

History: Patient back in today for his follow-up. She still having a lot of problems with his gait and walking ability. He's decided that he would go back and going physical therapy. His labs have been good. His INR was up slightly the last time and we held it for 48 hours. His last INR was down to 2.02, and he has restarted his warfarin. His hemoglobin is staying stable around 10 g. Stools are still mildly heme positive, but obviously we are limiting the amount of blood loss. His sugars are remaining elevated over 200 for the most part. He continues to have significant dietary indiscretions. He has been on 5 mg twice a day of his glipizide.

Physical Exam: Lung fields are clear. Valve click is unchanged. Obese abdomen. Still has one plus edema with his chronic stasis changes. He still has significant problems with his gait and balance. He does have evidence on his posterior neck again of some mild folliculitis. This has recently been biopsied by ENT services

ASSESSMENT: Chronic GI bleed. Diabetes type II poorly controlled. Renal insufficiency. Cor pulmonale. Severe per neuropathy with gait disturbance. Folliculitis.

PLAN: Patient will start on doxycycline 100 mg a day for the next week to treat his neck. We will increase his diabetic medicine to 10 mg in the morning and five in the evening. It is most likely that this gentleman is on end up on insulin therapy. We will get him back in to physical therapy at this time and see if we can make any difference with his balance or gait training. He is to follow up in two weeks.

Lynn N. Smith M.D.

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207

OFFICE NOTE

PATIENT NAME: Fitzwater Jackie

DATE: 11/7/2007

ACCOUNT NO. 001502

VITAL SIGNS: Wt. 100 and a 9.6 pounds, BP 104/62, pulse 88

History: Patient is back in today for his follow-up. He still having a lot of problems with his ambulation. They've basically given up I think with therapy on him since he hasn't really made progress and doesn't seem to be all that motivated. He states he has had some muscle soreness in his legs, which he believes is related to his exercise program. He still has significant problems with his balance and his gait because of weakness and his neuropathy.

REVIEW OF SYSTEMS: Weight is stable. Shortness of breath is stable. He still eats way too many calories a day and he tends to eat very high sugar content. Bowels have been working well. Edema has been under good control. Dyspnea has been stable.

Physical Exam: HEENT is unremarkable. Lung fields shows decreased breath sounds of his right bases with his known effusion. Cardiac shows his irregular rhythm with his valve click and murmur which is unchanged. He still has his marked truncal obesity. One to two plus tense edema still present but stable. Patient is unable to stand from a sitting position because of quad weakness. Balance is also still very poor. An essential tremor is noted on the left arm in particular. There is no evidence of cogwheeling or resting tremor at this time.

Laboratory: Hemoglobin is stable at 9.1. His electrolytes shows potassium is 5.5 with a sodium of 128. BUN/creatinine are stable. Hemoglobin A1c is elevated at 9%. We recently increased his glyburide to 5 mg b.i.d.

ASSESSMENT: Diabetes type II poorly controlled. Severe peripheral neuropathy. Status post valve replacement on chronic anticoagulation. COPD with pulmonary hypertension and cor pulmonale. Essential tremor.

PLAN: We again talked about his exercise and weight program. He needs to decrease his calorie intake and try to get his weight down and the sugars better controlled. He is up to him as to whether or not physical therapy will be beneficial for his weakness and his gait training. Repeat in his labs will be drawn in the next week. Follow up appointment in two weeks. Patient does have an essential tremor at this time. I have also asked them to discontinue the Reglan to make sure that this is not a contribute factor.

Lynn N. Smith M.D.

**Lynn Smith, MD
Valley Medical Associates
Route 2 Box 171
Lewisburg, WV 24901
304-645-3207
OFFICE NOTE**

PATIENT NAME: Fitzwater Jackie

ACCOUNT #: 001502

DATE: 10/24/2007

CHIEF COMPLAINT: Patient returns today for his follow up. Patient is doing well at this time.

HISTORY: Patient comes back in for his routine follow-up. Over the past month he's been doing fairly well. His blood sugars have been running elevated here lately. This gentleman eats a lot of calories. Each a lot of sweets, cookies, candy and carbohydrate.. He basically has justified this since he gave up the cigarettes. His weight has been doing well. He is doing better with physical therapy and his ambulation has improved. His last hemoglobin seven stable over the past month.

MEDICATIONS: , Feosol one t.i.d., Zylprim under milligrams daily, Reglan 10 mg t.i.d., Flomax .4 mg daily, protonic 40 mg b.i.d., glyburide 5 mg daily, Demadex 100 mg p.o. b.i.d., Synthroid .225 mg daily, Lanoxin .125 mg daily, warfarin 5 mg daily. Aldactone 100 mg b.i.d. Chantix 1 mg b.i.d.

ALLERGY: None

SOCIAL HISTORY: Patient says he has not smoked any cigarettes since he stopped after his last hospitalization

PHYSICAL EXAM: VITAL SIGNS weight 201.7 pounds, BP 122/72, pulse 88

GENERAL: Alert and in no apparent distress.

SKIN: Normal turgor. No cyanosis, jaundice, petechiae, rash, or open lesions. Several ecchymotic areas are located on his arms. **HEENT:** External auditory canals clear and tympanic membranes intact. No buccal mucosal abnormalities. Gingiva not inflamed. Tongue intact. Pharynx not inflamed. He has no pallor to his conjunctiva this time.

NECK: Supple. Trachea midline. No masses or thyromegaly. No jugular venous distension.

CARDIOVASCULAR: Regular rhythm. . . Has a valve click in his aortic region which is unchanged. Grade 2 murmur is noted. No diastolic component is audible. No S3 gallop is audible.. Carotid pulses full and symmetrical without bruits.

CHEST: Lungs clear with out rales, ronchi, or wheezes. Decreased breath sounds at the right base which is chronic .

ABDOMEN: Abdomen is protuberant bowel sounds are normal active. No fluid wave is noted swelling is much less than when he was recently hospitalized.

EXTREMITIES: Chronic stasis changes in his lower extremities are present. There is trace pitting edema at this time bilaterally. There are no open sores.

LYMPHATIC: No palpable submandibular, cervical, supraclavicular, axillary, or inguinal

lymphadenopathy.

Neuro: Patient's gait is better today. He has better motor strength in his leg and his balance appears to be better.

ASSESSMENT: 1. Recurrent GI bleeds secondary to small bowel AVM
2. Valvular heart disease status post aortic valve replacement
3. Diabetes type II not adequately controlled.
4. COPD/pneumoconiosis
5. Renal insufficiency

PLAN: Patient will increase his glyburide to 5 mg b.i.d. On Monday the home health nurses will be present and will get a hemoglobin A1c, protime, CBC and CMP drawn at that time. I've asked him to return in two weeks for follow-up. No other changes in medicines at this time.

Lynn N. Smith M.D.

05/19/2007

Lynn Smith M.D.

Re: Jackie Fitzwater

Dear: Dr. Smith,

Thank you for referring Jackie Fitzwater to me for a Colonoscopy. The procedure was performed on 05/19/2007.

The indications for this examination were:

- Anemia

The patient tolerated the procedure well and there were no complications.

The endoscopic findings listed below were noted during today's procedure:

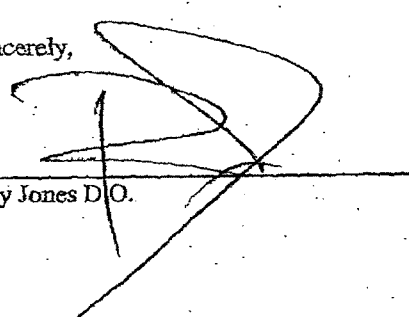
- Moderate internal and external hemorrhoids were present.

Based on the findings noted on today's examination and this patient's history I would recommend:

- None

Please find enclosed a copy of the report for your files. Thank you for an opportunity to assist in the care of this patient. Please feel free to contact me if I can be of further assistance to you. My office phone number is (304) 647-6023 or I can be reached via pager through my answering service at (304) 647-6023.

Sincerely,



Ray Jones D.O.

05/19/2007

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 05/19/2007

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.



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INTRODUCTION:

71 year old male patient presents for an elective inpatient colonoscopy. The indication for the procedure was anemia.

CLINICAL HISTORY & PHYSICAL EXAMINATION:

The patient's clinical history and physical examination were performed and are documented in the patient's record.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:

- Versed 3 mg IV throughout the procedure
- Demerol 75 mg IV throughout the procedure

PROCEDURE:

Rectal exam: Normal sphincter tone. Moderate internal and external hemorrhoids were present.

The endoscope was passed without difficulty under direct visualization to the cecum confirmed by landmarks and transillumination.

05/19/2007

255
App.000519

Greenbrier Valley Med. Center
Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 05/19/2007

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.

The quality of the preparation was fair.

IMPRESSION:

1. Moderate internal and external hemorrhoids [455.0].

PROCEDURE CODES:

45378: COLONOSCOPY TO CECUM.

Ray Jones D.O.

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 05/14/07 DISCHARGE DATE: 05/19/07
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Recurrent GI bleed, secondary to AV malformations of the small bowel.
2. Iron deficiency anemia, secondary to blood loss.
3. Chronic atrial fibrillation.
4. COPD.
5. Congestive heart failure, diastolic.
6. Severe pulmonary hypertension, with cor pulmonale.
7. Diabetes mellitus Type II.
8. Peripheral neuropathy.
9. Prosthetic aortic valve.

DISPOSITION:

The patient is discharged home to the care of his family. We will continue with Lovenox mg/kg sub q. until adequate anticoagulation. He is resuming his Warfarin 7 mg q. p.m. until therapeutic.

SUMMARY:

This is one of many admissions for this 71-year-old. He has a history of recurrent GI bleed secondary to AVM's involving the small bowel. He has had multiple endoscopies. He has had cauterization on two to three occasions. He has been chronically anticoagulated because of his prosthetic aortic valve. He subsequently remains anticoagulated and has periodic bleeds. He again, presented with increasing weakness, and a hemoglobin of less than 7. He developed shortness of breath, increasing edema and worsening failure, associated with this. He was hospitalized, and was transfused without complication. He was seen in consultation, and an EGD was performed, which was unremarkable. There were two small lesions that were cauterized at this time, but no other lesions were identified. With his transfusion he improved significantly and feels much better. He ultimately also had a colonoscopy, which showed no other specific lesions at this time. His hemoglobin was up to 9.5. He is tolerating his anemia well with no other evidence of active bleeding at this time. He is going to be discharged home in improved condition to follow up on an outpatient basis.

Lynn N. Smith, M.D.

D: 06/23/07 0850
T: 06/24/07 1308
LAM
PMT, INC. JOB#00938
cc:

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 05/18/07 at 0759

LOCATION: Recovery in endoscopy.

SUBJECTIVE: Mr. Fitzwater was just brought down to have a colonoscopy. Unfortunately, there was not an adequate prep. He is going to have this redone tomorrow. He is alert and oriented. He has not had any problems last night. He did have the diarrhea as one would expect with the bowel prep no unusual pain no nausea or vomiting. Shortness of breath has been stable. He has not noticed any active bleeding. His coagulation was held last night because of the attempted colonoscopy this morning.

OBJECTIVE: BP is 113/65, pulse is 90, respirations are 18, O2 sat is 96 % on room air. HEENT is unremarkable. Lungs show evidence of some mild wheezing especially on the right. He has a mild congested cough. Decreased breath sounds at the right bases noted. Cardiac shows his valve click. He has no murmurs, rubs or gallops. His abdomen is soft and nontender. He does have 1 + pitting edema. He is alert and oriented does not have any acute distress at this time.

LABORATORY: His hemoglobin is now up to 9.4. His PT is subtherapeutic at 1.3. Glucose is 71 and an IV has been started with D5 at this time since he is still NPO post anesthesia.

IMPRESSION:

1. Gastrointestinal bleed recurrent believe secondary to AVM's.
2. Anemia secondary to # 1.
3. Prosthetic valve, chronic anticoagulation.
4. Atrial fib.
5. Cor pulmonale with pulmonary hypertension.

PLAN:

1. We will restart his Lovenox this morning and then hold again the dose tonight.
2. He will have a re-prep and will be tried again tomorrow by Dr. Jones.
3. He is going to start on his Lasix 40 mg. daily at this time.
4. No other transfusions is necessary at this time.

Lynn N. Smith, M.D.

D: 05/18/07 0804

T: 05/18/07 0909

MKM

cc:

RECEIVED MAY 21 2007

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

PMT, Inc. Job #: 20949

RECEIVED MAY 21 2007

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: DR. Lynn N. Smith

DATE: 05/15/07 at 0748

LOCATION: Third floor.

SUBJECTIVE: Mr. Fitzwater was admitted last night with Warfarin toxicity, evidence of anemia. He has a history of chronic GI bleeding secondary to AV malformations some that were just cauterized in Charlottesville a couple of months ago. His INR within the last couple of weeks had been good running at about 3 to 3 1/2. For some reason he came in and had his INR up to 11. He says he had not taken any unusual medications. He says he had not filled any new prescriptions to the best of our knowledge there is no overt reason as to why this would suddenly become so toxic for him. He was found to be very anemic back down with his hemoglobin of about 7. He received treatments with both Vitamin K and fresh frozen. He was transfused and is still in the process of being transfused at this time so repeat numbers have not been performed this morning. He looks better. He is sitting up in the bed and actually feels better. He denies any pain, no nausea or vomiting. He has had no cough or sputum production, really does not describe any shortness of breath at this time.

OBJECTIVE: His BP is 104/44, pulse of 96, respirations 22 and O2 sat is 97 %. He still looks a little pale but his unit of blood is transfusing as we speak. He has dullness at his right base consistent with his known effusion. He has his valve click which is unchanged. No abdominal tenderness is noted. He does not have any unusual ecchymotic areas on his flank, back or in his legs. He has his 1 + pitting edema with his chronic stasis and his skin changes distally. He is alert and oriented with no focal neurological findings other than his severe peripheral neuropathy.

IMPRESSION:

1. Gastrointestinal bleed with anemia.
2. Warfarin toxicity.
3. Prosthetic valve due to rheumatic heart disease.
4. Severe pulmonary hypertension.
5. Diabetes.
6. Pneumoconiosis.

PLAN:

1. We will wait until he finishes his transfusions, repeat his labs.
2. We will have to within 24 hours start him back on some Lovenox because of his mechanical valve but we can leave him un-anticoagulated for at least 24 to 36 hours safely.
3. Will monitor his H & H.
4. He will obviously take a while to be re-anticoagulated with his Coumadin since he has had everything reversed at this time.

RECEIVED MAY 16 2007

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

Lynn N. Smith, M.D.

D: 05/15/07 0753

T: 05/15/07 0859

MM

CC:

PMT, Inc. Job #: 19926

RECEIVED MAY 16 2007

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 04/04/07 at 0730.

LOCATION: Third floor.

SUBJECTIVE: Mr. Fitzwater is still waiting for his bed at UVA. His hemoglobin was down to 7.9 and we subsequently did transfuse him 2 units of packed cells last night. Since that time he has felt better. His energy level has improved. He has not had any change in his shortness of breath, PND otherwise peripheral edema probably has increased slightly. Appetite has been good. Bowels have been stable. He is on Lovenox now as his PT has come back down to almost the normal range.

OBJECTIVE: He is afebrile, BP is 118/70 with a pulse of 76. Lung fields show decreased breath sounds of the right base. He has some scattered rhonchi with no wheezes. Cardiac shows his valve click with systolic murmur no diastolic components. Abdomen is obese, bowel sounds are active. Extremities do have an increase in 1 + edema. He has his chronic stasis changes due to his inflammatory changes in the past. His PT is now down with an INR down to 1.6. Repeat hemoglobin has not been drawn at this time as he finished his transfusion just a few hours ago.

IMPRESSION:

1. Recurrent gastrointestinal bleed secondary to probable small bowel AVM.
2. Status post aortic valve replacement due to rheumatic heart disease.
3. Pneumoconiosis - chronic obstructive pulmonary disease.
4. Diabetes mellitus.
5. Anemia.
6. Renal insufficiency.

PLAN:

1. I am going to restart his Lasix because he has been off of it for a number of days and is beginning to have some increased fluid retention.
2. He has received his transfusion.
3. He is stabilized at this time and we will hopefully get a bed to Charlottesville so he can be transferred to Charlottesville and have further evaluation of this persistent bleeding.
4. This patient has now required 8 units of blood transfusions over the last three weeks.

Lynn N. Smith, M.D.

D: 04/04/07 0737

T: 04/05/07 1352

MKM

RECEIVED APR 10 2007

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 03/29/07

DISCHARGE DATE:

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Recurrent GI bleed with a prior history of AV malformation.
2. Anemia secondary to #1.
3. History of restrictive pericarditis and cor pulmonale.
4. Pulmonary hypertension.
5. Pneumoconiosis.
6. Status post prosthetic aortic valve.
7. Diabetes mellitus type 2.
8. Prior history of toxic shock syndrome.
9. Benign prostatic hypertrophy.
10. History of chronic atrial fibrillation.
11. Renal insufficiency.

DISCHARGE MEDICATIONS: Prevacid 30 mg daily, Lanoxin 0.125 mg daily, Flomax 0.4 mg b.i.d., Glyburide 5 mg b.i.d., Metoclopramide 10 mg with meals, KCl 20 mEq daily, Allopurinol 10 mg daily, Warfarin currently on hold, Lovenox 1 mg/kilo subcu q. 12 hours, Triamcinolone to neck twice a day, Levothyroid 0.225 mg daily, Lasix 80 mg daily.

DISPOSITION: The patient is being transferred to the University of Virginia to the services of Dr. Paul Yaton for GI evaluation.

HISTORY OF PRESENT ILLNESS: This is a 70 year old man who has now received six units of blood over the last three weeks because of recurrent GI bleeding. He has a history of prior gastritis, but he has also had a history of AV malformation secondary to pulmonary hypertension and cor pulmonale. He did undergo a capsule endoscopy approximately a year ago and had a small bowel scope which did result in cauterization of one major AVM. He did well for a few months, but recently has been having increasing GI bleeding with progressive anemia. His hemoglobin has now been down to 7 on two occasions and he has required six units of blood over the last three weeks. With this, he becomes more short of breath. He has increasing weakness and dyspnea and marked decrease in his overall functional capacity.

HOSPITAL COURSE: He was brought in again because of his progressive anemia. At this time, stools were hemepositive. A bleeding scan was done at the time of his admission and unfortunately did not show any significant concentration of isotope. His platelets were normal. White count was normal. Iron studies were normal. His BUN was up to 80 with a creatinine of 2.5. His EKG showed atrial fib and his chest x-ray shows a chronic right effusion which is known to be loculated.

He was transfused three units of packed cells with a resulting hemoglobin of 10. Gradually over the next several days, his hemoglobin has dropped down now back to 8. His stools remained positive. His INR was elevated at 7. This was corrected to 1.7

***** DISCHARGE SUMMARY *****

APR 04 2007

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 03/29/07

DISCHARGE DATE:

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

and now he is on Lovenox and his Coumadin is currently on hold. At this time, it is felt that this gentleman is having recurrent bleeding, most likely again from small bowel origin. Since he is requiring multiple transfusions over the last several weeks, it is felt that we need to try to find a source and see if there is any way possible to get this treated to prevent him from having to have future frequent admissions with transfusions. He is being transferred to UVA at this time for that purpose. Hopefully, he can undergo further diagnostic testing and see if there is anything that we may be able to correct at this time.

Lynn N. Smith, M.D.

D: 04/02/07 1638

T: 04/03/07 1203

VGC

PMT, INC. #07740

***** DISCHARGE SUMMARY *****

RECEIVED APR 4 2007

GREENBRIER VALLEY MEDICAL CENTER

P. O. BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

PROGRESS NOTE

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DATE: 03/31/07, at 0847.

HISTORY OF PRESENT ILLNESS:

The patient feels quite a bit better at this time. He is up eating breakfast, and feels good. He is not having any pain, shortness of breath has improved. His weakness has improved. He has actually been ambulating well with his walker in the room. He has not had any nausea, vomiting. He denies any nausea, diarrhea. His bowels have moved. He is voiding well at this time. His affect is quite a bit better. He has no new major complaints at this time.

OBJECTIVE:

Vital signs: Blood pressure is 120/65. Temperature is 97. Pulse 90. Respirations 20. HEENT: Pupils equal and reactive. No scleral icterus. He has decreased breath sounds in his right base, where there is known chronic effusion. His valve click and murmur is unchanged, with no new murmur. Abdomen: Obese. Extremities: Warm. He has trace peripheral edema at best. It is quite good. Chronic stasis changes in his skin. He still has a few lesions on his back and neck which he tends to excoriate. There have been infected hair follicles in the past. Labs: Hemoglobin has dropped down to 8.8, with probable equilibration. His INR is slightly low now at 1.7. Stool is hemoccult positive. His bleeding scan failed to demonstrate any focal activity, so it is felt this is not an active enough bleed to register on that scan.

IMPRESSION:

1. Anemia with chronic GI blood loss.
2. Chronic atrial fibrillation with congestive heart failure and pulmonary hypertension.
3. Renal insufficiency.
4. Status post aortic prosthetic valve on anticoagulation.

PLAN:

1. We are going to continue to monitor for now. We will watch his counts and PT tomorrow. If his INR does not begin to come back up, then we will consider starting him on Lovenox, until such time this will remain therapeutic due to his prosthetic valve.
2. H&H and electrolytes will be monitored.
3. If he continues to bleed, then we will have to reevaluate his bowels and spend some time, and we are assuming it will be the AV malformations that are the problem, but there may be a second dominant issue, that will need reevaluation. This will be determined by how his counts maintain.

Lynn N. Smith, M.D.

D: 03/31/07 0855.

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265

App.000529

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.330 UNIT #: D000038770
ADMISSION DATE: 03/29/07
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: This is a 70 year old with multi-system disease who has been hospitalized on numerous occasions. His principal problem this time is that he has a history of recurrent GI bleeds due to AV malformations. He has had a history of pulmonary hypertension, cor pulmonale because of a combination of restrictive lung disease and valvular heart disease. He began having increasing weakness, shortness of breath. He was just transfused three weeks ago with blood because of the anemia. He has chronic bleeding. Unfortunately he also has to be chronically anticoagulated because of his prosthetic valve so we basically have never been able to stop this process. He began having increasing shortness of breath. He has been staggering, could not walk, dyspneic and was brought to the ER where he was found to have a hemoglobin of 7.5. He denies any chest pains. His shortness of breath is worse with exertion, better with rest. He has not really had any change in his bowel habits. His stools were always black because he was on iron chronically. He is basically being admitted for transfusion and re-evaluation of his bleeding problems.

PAST MEDICAL HISTORY: He has known chronic congestive heart failure with marked pulmonary hypertension. He has COPD/pneumoconiosis. He is a Type 2 diabetic. He has a history of restrictive pericarditis. He has a history of rheumatic heart disease with subsequent aortic valve replacement. He has also had two episodes of toxic shock syndrome with strep cellulitis. He has had history of some renal insufficiency and is on chronic anticoagulation and atrial fib. He has known BPH.

PAST SURGICAL HISTORY: He has had a valve replaced. He has had a pericardial stripping. He has an appendectomy, cholecystectomy, prostate surgery with microwave. He has also had a circumcision and a permanent pacemaker due to tachybrady syndrome.

ALLERGIES: He has no known drug allergies.

MEDICATIONS: List as noted. They are provided for in his records.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He is still unfortunately smoking but only a few cigarettes a day. No significant alcohol.

FAMILY HISTORY: Unremarkable. There is a positive history for diabetes, heart disease, hypertension.

REVIEW OF SYSTEMS:

HEENT: He hears well. Sees well. No difficulty in swallowing.

CHEST: He does have a minimal cough. He has been short of breath recently. He has a known chronic right pleural effusion that is loculated.

CARDIAC: No chest pains, palpitations.

GI: No change in bowel habits. No nausea, vomiting or diarrhea.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

GU: He is voiding quite well now since he has had his microwave surgery.
ENDOCRINE: No polyuria, polydipsia.
SKIN: He has some multiple ecchymotic areas, itching some too for some reason. He tends to scratch and almost has a neurodermatitis at times. He has minimal arthritic complaints with his knees and back. He has prior history of gout.

PHYSICAL EXAMINATION: He is alert and oriented. His blood pressure is about 120/70 with respirations 20. He is very pale. He has some ecchymotic areas on his skin, on his arms and his legs due to his trauma. No petechial rashes noted.
HEENT: Posterior pharynx is clear. Membranes are dry.
NECK: Supple. Thyroid is not enlarged and his carotids are normal.
LUNGS: Decreased breath sounds at the right base chronically but he has no other rales or rhonchi. He has a valve click with a systolic ejection murmur. No diastolic component at this time.
ABDOMEN: Obese. Bowel sounds are active, no organomegaly, tenderness or bruits.
EXTREMITIES: Warm. He has only minimal edema for him which is quite a bit, improved. He has chronic stasis dermatitis on his legs but there is no evidence of active weeping. No open lesion.
NEUROLOGICAL: He is alert and oriented. He moves his extremities but is diffusely weak. He has severe neuropathy. He has virtually no feeling in his knees distally. This gentleman really just cannot feel because of a severe neuropathy. Also has a little numbness in his right hand. No focal motor abnormalities.

His hemoglobin is 7.5; platelets and white count normal. BUN 80 with creatinine 2.5. EKG shows atrial fib. Chest x-ray is unchanged.

IMPRESSION:

1. Anemia with history of recurrent GI bleed.
2. Restrictive pericarditis with severe cor pulmonale and pulmonary hypertension.
3. Pneumoconiosis.
4. Chronic atrial fib.
5. Valvular heart disease, status post aortic valve replacement.
6. Diabetes Type 2.
7. Severe peripheral neuropathy.

PLAN:

We are admitting him at this time, w/ill transfuse him. Will try to get a bleeding scan to see if perhaps there is enough blood loss now that might trigger what part of the bowel we are losing it in. We will monitor his pro time and try to keep him at

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

the lower limits of acceptability for him. He is going to continue with his other routine meds. Will hold his diuretics for now since his BUN and creatinine are so high and watch his daily weights.

Lynn N. Smith, M.D.

D: 03/29/07 1757

T: 03/30/07 0742

MAF

PMT, Inc. #06810

cc:

RECEIVED APR 02 2007

Lynn N. Smith M.D.
RT.2 Box 171 Lewisburg, WV 24901
304-645-3207
OFFICE NOTE

PATIENT NAME: Fitzwater Jackie
DATE: 5/24/2007
ACCOUNT NO. 001502

VITAL SIGNS: Weight 211.2 pounds, BP 126/58, pulse 84

History: This 71-year-old male returns after a hospitalization. He had an episode of GI bleeding with Coumadin toxicity. He has a long-standing history of recurrent GI bleeds due to AVMs. His hemoglobin was at a 6.7. His INR was elevated at 11.6. He was given fresh frozen plasma and vitamin K. Received a total of five units of blood. His last hemoglobin was just checked at 10.2. He's not noticed any further bleeding. He did have a colonoscopy while hospitalized that showed no new source of bleeding.

REVIEW OF SYSTEMS: Weight is up approximately 12 pounds. He denies any shortness of breath, PND or orthopnea. He has noticed a rash on his arms and on his scalp. It has been itching and he has subsequently scratched it. He has noted some increased swelling actually took one of his extra metolazone tablets.

Physical Exam: He has a diffuse rash on his arms and some in the scalp. This appears to be more follicular, consistent with folliculitis. Lung fields show decreased breath sounds at the right base. Cardiac shows his valve click with no new murmurs. He does have two plus pitting edema. Chronic stasis changes on his legs. He does not appear to be pale. No palpable organomegaly.

Patient's INR at this time is 1.9 — still slightly subtherapeutic.

ASSESSMENT: Recurrent GI bleed due to small bowel AVMs. Severe cor pulmonale with pulmonary hypertension. Diabetes type II. Valvular heart disease. COPD. Probable folliculitis

PLAN: Patient will begin on Bactrim DS one twice a day to cover the possibility of MRSA. She will take his extra booster pill for the next two days. A repeat of his INR will be done Monday along with a CBC and basic metabolic panel. He will continue on Lovenox subcutaneous until INR is therapeutic.


Lynn N. Smith M.D.

Patient Name Jackie Fitzwater Age 71 Date 5-1-07Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.Chief Complaint F10-

Pertinent Past Medical History

Past Surgical History

Medications

GENERALCARDIOVASCULARRESPIRATORYGASTROINTESTINAL

JACKIE FITZWATER

5/1/2007

S: Mr. Fitzwater has been to Charlottesville. They did cauterized 2 other AV malformations in his small bowel. His last hemoglobin was 9.7. He is doing pretty well. His weight is down. He feels good. His activity level has been good and his blood pressure has been holding. We have not seen any active bleeding, but we have also not checked any recurrent stools. He is now off the Lovenox and his INR is 2.7. He is back on his 7 alternating 8 mg dose of his Warfarin, which is what has been a stable dose for him in the past.

MINUTES

FAMILY HISTORYPHYSICAL EXAM:Ht _____ Wt 195 BP 120/60 Pulse 76 Temp _____ Resp _____EXAM

Normal	Abnormal	Comment
General		
Head		
Eyes		

LAB

A1C
ALT/LIVER
BMP-CMP
CBC

INR
2.7

REVIEW OF SYSTEMS: Appetite has been good. No chest pains or palpitations. Shortness of breath has been stable. He has been having a few leg cramps, which he takes some Tylenol. Swelling has been down. No GU or GI symptoms otherwise.

EXAMINATION: He has a good blood pressure 120/70. His weight is actually down 5 pounds in the 195 range. Lung fields show his decreased breath sounds at his right base with his chronic effusion. His valve click is unchanged. He has still his truncal obesity. He has trace peripheral edema, which is good for him.

IMPRESSION:

1. History of recurrent GI bleeds due to small bowel AVM.
2. Valvular heart disease status post aortic valve replacement.
3. Cor pulmonale with pulmonary hypertension.
4. Diabetes mellitus.

PLAN: We are going to have him redraw his labs tomorrow when the health nurses come to see him. He is going to continue with his same other medications for now. We will determine next course of action as how he does with his H&H. If it continues to drop then obviously they are planning to return to Charlottesville where they will consider both a colonoscopy and a capsule endoscopy of his small bowel.

Lynn N Smith, MD/NM/aw

Greenbrier Valley Medical Center

P.O. Box 497
Phone #: (304) 647-6075

Ronceverte, WV 24970
Fax #: (304) 647-6525

Pt. Name: FITZWATER, JACKIE L
DOB: 04/25/1936
Age/Sex: 70/M
Unit #: D000038770
Admit Diagnosis: ANEMIA
Exam Date: 09/18/2006

Attending M.D.: Smith, Lynn N.
Ordering M.D.: Durham, Richard R
Location: D.331 A
Status: ADM IN
Radiology #: 38246
Account #: D00098536997

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

Exams: 000677189 CT ABDOMEN W/O CONT,
000677304 CT PELVIS W/O CONTRAST

CLINICAL HISTORY: FOLLOWUP RECTUS MUSCLE HEMATOMA, ANEMIA

Axial nonenhanced sections were performed through the abdomen and pelvis without oral contrast medium.

Comparison was made with the prior study of 9/15/06.

There is a small to medium size right pleural effusion (unchanged).

There is moderate patchy atelectasis in the right basilar area (unchanged).

There is a small amount of ascites in the upper abdomen (unchanged) and there is a new small amount of ascites in the pelvic area.

There is a complex mass involving almost the entire left rectus abdominis muscle. This most likely reflects rectus hematoma. It now measures about 13 x 7 cm in greatest transverse and AP diameters. It has increased in size considerably relative to previous.

There is moderate atheromatous calcification in the abdominal aorta.

There is a small cyst in the inferior right lobe of the liver.

The spleen, pancreas, adrenals and kidneys are normal. There is gas in the urinary bladder. There is a Foley catheter in situ and this presumably relates to the catheterization.

There are numerous prostatic calculi.

There are bilateral inguinal hernias containing fat.

There is mild to moderate cardiomegaly.

IMPRESSION: MULTIPLE ABNORMALITIES AS NOTED. OF PARTICULAR

PAGE 1

Lynn Smith, M.D.

(Continued)

Greenbrier Valley Medical Center

P.O. Box 497
Phone #: (304) 647-6075

Ronceverte, WV 24970
Fax #: (304) 647-6525

Pt. Name: FITZWATER, JACKIE L
DOB: 04/25/1936
Age/Sex: 70/M
Unit #: D000038770
Admit Diagnosis: ANEMIA
Exam Date: 09/18/2006

Attending M.D.: Smith, Lynn N.
Ordering M.D.: Durham, Richard R
Location: D.331 A
Status: ADM IN
Radiology #: 38246
Account #: D00098536997

Exams: 000677189 CT ABDOMEN W/O CONT,
000677304 CT PELVIS W/O CONTRAST

<Continued>

SIGNIFICANCE HERE, IS AN INCREASING RECTUS SHEATH HEMATOMA.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

**** Electronically Signed by Colin Rose M.D. on 09/18/2006 at 1707 ****
Reported and Signed by: Colin Rose, M.D.

S

CC: Richard R Durham, D.O.; Lynn Smith, M.D.

Dictated Date/Time: 09/18/2006 (0000)
Technologist: Kathryn A Hughes RT(R) (RDMS) CT; ...
Transcribed Date/Time: 09/18/2006 (1601)
Transcriptionist: PMILMC
Orig Print D/T: S: 09/18/2006 (1707) Batch No: 770

PAGE 2

Lynn Smith, M.D.

RECEIVED SEP 20 2006

Greenbrier Valley Medical Center

P.O. Box 497
Phone #: (304) 647-6075

Ronceverte, WV 24970
Fax #: (304) 647-6525

Pt. Name: FITZWATER, JACKIE L
DOB: 04/25/1936
Age/Sex: 70/M
Unit #: D000038770
Admit Diagnosis: GI BLEED ANEMIA
Exam Date: 08/31/2006

Attending M.D.: Smith, Lynn N.
Ordering M.D.: Smith, Lynn N.
Location: DRD
Status: REG CLI
Radiology #: 38246
Account #: D00098533426

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

Exams: 000674009 NM ACUTE GI BLEED

BLEED SCAN:

21.1 mCi tagged RBC's obtained.

No evidence for focal area that would be in definite keeping with bleed. There is increased activity in the region of the spleen.

IMPRESSION:

1. NO EVIDENCE FOR DEFINITE IDENTIFIABLE BLEED.
2. CONSIDER EVALUATION CT OF THE ABDOMEN AND PELVIS SUGGESTED.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

**** Electronically Signed by David C Maki D.O. on 09/01/2006 at 1448 ****
Reported and Signed by: David C Maki, D.O.

CC: Lynn Smith, M.D.

Dictated Date/Time: 09/01/2006 (0000)
Technologist: David L Weikle RT(R) (N); Jennifer K Bullock RT(N)
Transcribed Date/Time: 09/01/2006 (1207)
Transcriptionist: PMTLMC
Orig Print D/T: S: 09/01/2006 (1448) Batch No: 680

PAGE 1

Lynn Smith, M.D.

Greenbrier Valley Medical Center

P.O. Box 497
PHONE #: (304) 647-6075

Ronceverte, WV 24970
FAX #: (304) 647-6525

PT. NAME: FITZWATER, JACKIE L.
DOB: 04/25/1936
AGE/SEX: 66/M
UNIT #: D000038770
ADMIT DIAGNOSIS: EARLY SATIETY
EXAM DATE: 11/13/2002

ATTENDING M.D.: Smith, Lynn N.
ORDERING M.D.: Smith, Lynn N.
LOCATION: DRD
STATUS: REG CLI
RADIOLOGY #: 38246
ACCOUNT #: D00098283739

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000420719 GI UPPER SERIES W/AIR CONTRAST

CLINICAL HISTORY: EARLY SATIETY

There is moderate tertiary wave formation (esophageal incoordination and spasm) involving the distal third of the esophagus. The stomach, duodenal cap and loop are normal. There was moderate gastroesophageal reflux.

IMPRESSION: ESOPHAGEAL DYSMOTILITY. GASTROESOPHAGEAL REFLUX.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** Electronically Signed by Colin Rose M.D. on 11/13/2002 at 1559 **
Reported and Signed by: Colin Rose, M.D.

✓ *APF on 11/13/02*

S

CC: Lynn Smith, M.D.

Dictated Date/Time: 11/13/2002 (1137)

Technologist: Ruth E Craft RT(R) (M)

Transcribed Date/Time: 11/13/2002 (1245)

Transcriptionist: PMTLMC

Printed Date/Time: 11/13/2002 (1606) BATCH NO: 1052

PAGE 1

Lynn Smith, M.D.

RECEIVED NOV 18 2002

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Admission: 05/14/2002
Discharge: 05/30/2002

Attending Physician: Eric R Powers, M.D.

Referring Physician: Lynn Smith, M.D.

PRIMARY DIAGNOSES: 1. Group A Strep toxic shock syndrome. 2. Renal failure.
3. Gastrointestinal bleed. 4. Left lower extremity cellulitis. 5. Atrial
fibrillation.

SECONDARY DIAGNOSES: 1. Status post St. Jude's aortic valve replacement. 2.
Chronic obstructive pulmonary disease. 3. Diabetes mellitus. 4. Hypothyroidism.
5. Hypertension.

PROCEDURES PERFORMED: 1. Insertion of a Swan-Ganz catheter through the right
internal jugular vein on 5/14/2002. 2. Continuous venovenous hemodialysis for
acute renal failure. 3. Status post multiple multiple packed red blood cells and
fresh frozen plasma transfusions. 4. Transesophageal echocardiogram on 5/14/2002.
5. Esophagogastroduodenoscopy and colonoscopy on 5/22/2002.

BRIEF HISTORY: This patient is a 66-year-old white male with a St. Jude's aortic
valve which was placed in 12/98 who was transferred from Greenbrier Hospital for
group A Strep bacteremia. He also has a history of atrial fibrillation, diabetes
mellitus, hypertension, hypothyroidism, and chronic obstructive pulmonary disease
who went to the outside hospital emergency room at about noon on 5/13/2002 with a
temperature of 103.4, and respiratory failure. His ABG at that time showed a pH of
7.48, pCO2 40, O2 78 on 60% FIO2. The patient was started on IV fluids,
nebulizers, and Solu-Medrol. He had an increased heart rate in the ICU and he was
digoxin loaded and given IV diltiazem and put on a drip on the morning prior to
transfer here. He denied any chest pain, but he did have some increase in lower
extremity edema. A chest x-ray there showed cardiomegaly and pulmonary edema, and
there was questionable left upper lobe infiltrate and 5/6 blood cultures came back
positive for group A Strep. His next ABG showed pH 7.23, pCO2 50 and pO2 74 on
50%. He had been started on Fortaz, gentamicin and vancomycin at the outside
hospital. He received morphine as well as an IV nitroglycerin drip, and Lasix and
BiPAP. His shortness of breath and heart rate continued to decline, and the
patient was then intubated and transferred to UVA CCU. Upon arrival at the CCU,
his systolic blood pressure was 50, on a dopamine drip, and he was immediately
started on Levophed. He had significant ectopy and a heart rate in the 150s after
the addition of dopamine and norepinephrine and therefore an emergent right
internal jugular vein Cordis was placed.

PAST MEDICAL HISTORY: 1. St. Jude's aortic valve replacement in 12/98 for
bicuspid aortic stenosis associated with syncope. He had a cardiac catheterization
in 1999 which revealed significant constrictive physiology which was initially
managed medically, but then the patient had to undergo pericardiectomy for symptom
management. 2. Diabetes mellitus. 3. Hypertension. 4. Hypothyroidism. 5.
Chronic obstructive pulmonary disease. 6. Paroxysmal atrial fibrillation. 7.
History of right lower extremity group A strep cellulitis. 8. Status post
cholecystectomy. 9. Status post appendectomy. 10. History of recurrent
transudative right pleural effusion.

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Admission: 05/14/2002
Discharge: 05/30/2002

SOCIAL HISTORY: He has an 80 pack year history of tobacco, and quit in 1998. He is a retired coal miner. He denies any alcohol or IV drug abuse.

FAMILY HISTORY: His mother has diabetes mellitus, his father with a stroke, but there is no significant coronary artery disease.

MEDICATIONS: On transfer, this includes: 1. Gentamicin 400 mg IV q.24h. 2. Vancomycin 1 gram IV. 3. Fortaz 2 grams IV. 4. Glipizide XL 5 q.a.m. 5. Coumadin 6 mg/7 mg q.o.d. 6. Finasteride 5 mg q.a.m. 7. Synthroid 0.030 q.d. 8. Omeprazole 20 mg q.d. 9. Paxil 20 mg q.d. 10. Gabapentin 400 mg q.d. 11. Colace 100 mg q.d. 12. Psyllium 3.7 grams q.d. 13. Zaroxolyn 2.5 mg q.d. 14. Reglan 10 mg b.i.d. 15. KCL 10 mEq q.i.d. 16. Demadex 100 mg b.i.d.

REVIEW OF SYSTEMS: Unable to be obtained because the patient was intubated and sedated.

PHYSICAL EXAMINATION: Vital signs revealed a blood pressure which was subsequently 110/69, heart rate 115, respiratory rate 30, saturation 96%. His ventilator was set on SPSV with an FIO2 of 60%, tidal volume of about 900 and a pressure support of 10, PEEP of 5. In general, the patient was intubated and sedated. **HEENT:** Pupils equally reactive to light and accommodation. Extraocular movements intact. Neck: Thick, unable to see jugular venous distention. Chest: Coarse breath sounds bilaterally, slight right crackles at the base. Heart: Irregularly irregular with crisp S1 and S2 without murmurs. Abdomen obese, slightly distended, normoactive bowel sounds. Extremities: Brawny edema, skin changes bilaterally, 2+ pitting edema bilateral lower extremities. There were no Janeway lesions, Osler's nodes, or splinter hemorrhages identified. Fundoscopic examination was within normal limits. There was significant erythema of his left lower extremity as well as his right upper forearm.

LABORATORY: On admission, WBC was 24, with 95% neutrophils, hematocrit 34 and platelets 239. His electrolytes showed sodium of 130, potassium 5.4, chloride 96, bicarbonate 24, BUN/creatinine 37/3.3. Glucose 164. His urinalysis showed moderate leukocyte esterase as well as 5-10 WBC but there were 5-10 epithelial cells in that sample. Troponin was <0.5. His INR was 3.6 and partial thromboplastin time 43. Digoxin level was 0.6 and albumin 3.3. Calcium was about 8. Total bilirubin 1.3, alkaline phosphatase 141. LDH 310. Chest x-ray showed interstitial edema bilaterally, cardiomegaly and a right pleural effusion. ABG at UVA showed a pH of 7.39, pCO2 38 and O2 241 on 100% FIO2. His second troponin became 0.92. His MB was 12 and index was 1.8. EKG showed atrial fibrillation with T wave inversion laterally and in leads 2, 3 and AVF. He did have some PVCs. His phosphorus was noted also to be elevated at 5.4.

HOSPITAL COURSE: The patient was admitted to the CCU. We will condense his long hospital course into a summarized review by systems: 1. Cardiovascular - The concern, obviously, was that his bacteremia was for valvular abscess, even though group A strep is not known to particularly cause endocarditis. An Infectious Disease consultation was obtained, and synchronously transesophageal echocardiogram was performed. There was no evidence of a valvular abscess on that echocardiogram, but it was somewhat difficult to read. The left ventricular function was read as normal, and the mechanical aortic valve did have a cystic posterior structure in the aortic root that was most consistent with abnormal sinus of Valsalva rather than an abscess. There were no obvious vegetations seen. As a result, he was resuscitated as described previously with pressors and inotropes. He was loaded on

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Admission: 05/14/2002
Discharge: 05/30/2002

amiodarone for his atrial fibrillation once his mean blood pressures were greater than 60 on dopamine. After his amiodarone load, his dose was decreased over his hospital course to 200 mg q.d. for atrial fibrillation. He did actually, by 5/20/2002, convert to normal sinus rhythm. He was kept on his heparin anticoagulation for his St. Jude's aortic valve during his stay. From a cardiovascular standpoint, the pressors were ultimately able to be weaned off, as his sepsis and hypotension improved. He was tolerating his dose of 200 mg of amiodarone well, and it was ultimately discontinued and he remained in sinus rhythm for the remainder of his stay. 2. Infectious Disease - From an Infectious Disease perspective, his hypotension, group A Strep bacteremia, left lower extremity cellulitis and possible portal of entry, and renal failure, made the diagnosis of Strep toxic shock syndrome likely. He was therefore started on penicillin G as well as clindamycin for the eagle effect. Given that there is small data to show that IVIG may improve outcomes in group A Strep toxic shock syndrome, although retrospective, he was also started on this for 5 days. An MRI of that left lower extremity was done in order to rule out necrotizing fasciitis. While there is extensive cellulitis noted on that MR there was no evidence of necrotizing fasciitis. We kept a close eye on his leg, as well as his other skin lesions, in order to evaluate for necrotizing fasciitis. There seemed to be no evidence of this. He did have a stable right pleural effusion which, with the history of group A Strep bacteremia, was of course concerning. As a result, we loaded him with fresh frozen plasma and he had his pleural fluid drained by radiology under ultrasound guidance. There were no bacteria noted on the gram stain and the WBC and the fluid was 770. It was exudative by _____ criteria. He was treated for a total course of 14 days with the penicillin and clindamycin for group A Strep toxic shock syndrome. After that he was changed to Augmentin per Infectious Disease recommendation, and wound care was consulted. His legs were elevated accordingly. He was continued on that Augmentin for three weeks after his discharge. 3. Renal - From a renal perspective, the patient's creatinine kept increasing during his initial hospitalization to a peak of about 6. With his hypotension, and capillary leak syndrome, he was barely able to maintain intravascular volume and thereby perfuse his kidneys. He did have to undergo CVHD in order to better improve his urine output. Renal was obviously consulted for this, and they thought that most of his renal failure was prerenal in etiology, secondary to his third spacing from his sepsis, as well as the GI bleed that he sustained which I have not spoken of yet but will. He was started on Epogen per their recommendations to treat his anemia as well. His creatinine eventually decreased to its baseline during the course of his hospitalization after recovery from his septic event. His creatinine on the day of discharge was actually 1.7. 4. GI - As mentioned earlier, he did have a GI bleed while he was in-house. Our differential for this included peptic ulcer disease given that he was on aspirin and Coumadin, as well as stress ulcer also a possibility because he was in the unit, as well as ischemic colitis. It was difficult to tell whether this was an upper or lower source especially since there was melena, although EGD only showed evidence of two small ulcerations which were not actively bleeding, and colonoscopy did not reveal any evidence of ischemic colitis. Nevertheless, he was kept on IV pantoprazole during this period, and his enoxaparin was changed to heparin in order to provide soft anticoagulation for a PTT aimed at 60 for his valves during the course of his GI bleed. It was self limiting, and his IV pantoprazole was changed over to high dose Nexium and he did not have any further episodes of GI bleeding after this event. His C. diff during this time was negative. 5. Respiratory - From a respiratory perspective, the patient tolerated extubation on day #3 after his transfer to UVA. His settings were minimal at that time, and he did well post extubation. However, with his GI bleed and significant third spacing, he did need to get reintubated for his EGD and

Page 3 of 5

OFFICE COPY FOR: Lynn Smith, M.D., DICTATED BUT NOT READ

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Admission: 05/14/2002
Discharge: 05/30/2002

colonoscopy procedures. As soon as those were over, he was extubated the next day and continued on his inhalers for his severe chronic obstructive pulmonary disease.

Ultimately the patient was transferred to the floor and received aggressive physical therapy and occupational therapy. He was seen by nutrition and was eating well by the time he was considered stable for discharge which was at least 13 days after he had hit the floor. He felt as if he is ready to go home on 5/30/2002, after discussion with his family, who also felt that he had come a long way.

DISCHARGE MEDICATIONS: 1. Demadox 100 mg p.o. q.d. 2. Synthroid 0.03 mg q.d. 3. Nexium 40 mg b.i.d. 4. Warfarin 6/7 mg q.o.d. 5. Augmentin 875 mg p.o. b.i.d. 6. Solu-Medrol 2 puffs b.i.d. 7. Albuterol 2 puffs q.6h. p.r.n. for wheezing. 8. Atrovent 2 puffs q.6h. p.r.n. for wheezing. 9. Glucotrol XL 5 mg q.d. 10. Finasteride 5 mg q.d. 11. Paxil 20 mg q.d. 12. Gabapentin 400 mg q.d. 13. Metolaxone 2.5 mg q.d. 14. Potassium chloride SR capsule 10 mEq b.i.d.

DISCHARGE DIET: Heart healthy, diabetic.

DISCHARGE ACTIVITY: As tolerated. The patient was instructed to elevate his legs several hours a day to reduce his swelling in the lower extremities.

Outpatient prescriptions have been written for him for an obesity walker with 300 pound wheels secondary to his left lower extremity cellulitis and complicated hospital course.

FOLLOWUP: Followup is with his local doctor, Lynn Smith, M.D., on 6/11/2002 at 10:30. He is also to have his INR drawn at this time.

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
DISCHARGE SUMMARY

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Admission: 05/14/2002
Discharge: 05/30/2002

Dictated and Dated by:

Shetal H Padia, M.D.
Resident
Internal Medicine

Signed and Dated by:

Eric R Powers, M.D.
Attending
Internal Medicine

SP/mng Job: 000021770 D: 06/11/2002 11:48 A T: 06/12/2002 10:03 A

cc: Eric R Powers, M.D.
Box 800662
Charlottesville VA 22908

Lynn Smith, M.D.
Rt 2 Box 171
Lewisburg WV 24901



05/30/2002

Patient's Name: Fitzwater, Jackie Lee
Medical Record: 120-44-22

Lynn Smith, M.D.
Route 2, Box 171
Lewisburg, WV 24901

Dear Lynn:

Jackie Fitzwater is being discharged from our hospital today, 5/30/2002. As you know, he presented with a streptococcal cellulitis and toxic shock syndrome. This was complicated by multiple organ failure. At a time that his INR was greater than 6, he developed significant gastrointestinal bleeding. Upper and lower endoscopy was negative. He was uremic for several days and required some brief dialysis. There was some atrial fibrillation, which has now resolved. Early in his course he had respiratory failure requiring intubation.

He has now been recovering gradually over the last several days. We will send you a detailed discharge summary as well as his current medications. He is now on oral antibiotics for the cellulitis. We will have him see you next week in follow-up. His INR is still not quite therapeutic. Because of his gastrointestinal bleed, I am reluctant to send him home on enoxaparin therapy; thus, I think the wisest course is to let his INR creep into the therapeutic range.

Hopefully, Mr. Fitzwater will continue to make a good recovery from this very complex illness. I will not plan to see him back in routine follow-up. However, please let me know if I can help with his care in the future. We appreciate the opportunity to participate in the care of this nice gentleman.

OFFICE COPY FOR: Lynn Smith, M.D., DICTATED BUT NOT READ

Patient's Name: Fitzwater, Jackie Lee
Medical Record: 120-44-22
Page 2 of 2

Best regards,

Sincerely,

Eric R Powers, M.D.
Attending
Internal Medicine

EP/tra Job: 000015944 D: 05/30/2002 12:28 P T: 06/04/2002 7:11 A

cc: Lawrence W Gimple, M.D.
Box 800158
Charlottesville VA 22908

Lynn Smith, M.D.
Rt 2 Box 171
Lewisburg WV 24901

OFFICE COPY FOR: Lynn Smith, M.D., DICTATED BUT NOT READ

to: Lynn Smith, M.D.

From: University of Virginia Health System Page 2 of 3

Friday, July 12, 2002 5:41:12 PM

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
ENDOSCOPY REPORT

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Date of Endoscopy: 05/23/2002

Physician: M Khalouck Abdrabbo, M.D.
Attending: M Khalouck Abdrabbo, M.D.

PREOPERATIVE DIAGNOSIS: Gastrointestinal bleeding.

POSTOPERATIVE DIAGNOSIS: Incomplete colonoscopy secondary to suboptimal prep, however, no active bleeding or source of blood loss identified.

PROCEDURE PERFORMED: Incomplete colonoscopy.

MEDICATIONS: Versed drip and fentanyl drip.

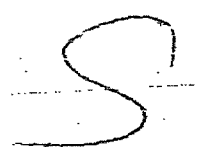
INSTRUMENT: CF-140L colonoscopy.

DESCRIPTION OF PROCEDURE: A description of the procedure including its risks, benefits, complications, and alternatives to the procedure were explained to the patient's family member and informed consent obtained. The patient was then placed in the left lateral decubitus position while intubated in the CCU. Conscious sedation was administered via a versed and fentanyl continuous drip. Vital signs including heart rate, blood pressure, respiratory rate, and oxygen saturations were monitored throughout the procedure. Digital rectal exam revealed liquid stool on the glove, however, no blood or melena noted. Colonoscope was then inserted through the anus and advanced to the transverse colon and further advancement was limited secondary to suboptimal prep. Despite multiple flushings and aggressive suctioning, we were unable to clear a sufficient amount of stool to safely continue with the exam. At that point, the colonoscope was withdrawn examining the colon as we approached the level of the rectum. No active bleeding source or old blood was identified in the colon. No large, obstructing mass lesions were identified, although smaller lesions may have been missed secondary to the patient's suboptimal prep. Multiple diverticulae were noted in the left colon, otherwise unremarkable exam.

IMPRESSION: Suboptimal prep due to retained liquid stool throughout the colon. Unable to advance the colonoscope beyond the hepatic flexure given poor quality of prep. No active bleeding or source of blood loss identified on exam.

RECOMMENDATIONS: 1. Monitor for further bleeding and supportive care as indicated. 2. Further recommendations per DHSC consultation team.

M. Khalouck Abdrabbo, M.D. was present throughout the procedure.



OFFICE COPY FOR: Lynn Smith, M.D., DICTATED BUT NOT READ

Page 1 of 2

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App.000546

To: Lynn Smith, M.D.

From: University of Virginia Health System Page 3 of 3

Friday, July 12, 2002 5:41:13 PM

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
ENDOSCOPY REPORT

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Date of Endoscopy: 05/23/2002

Dictated and Dated by:

Reviewed by
Michael K Sanders, M.D. 07/12/2002 11:53

Michael K Sanders, M.D.
Fellow
Internal Medicine

Signed and Dated by:

M Khalouck Abdrabbo, M.D.
Attending
Internal Medicine

MS/tra Job: 000014990 D: 05/28/2002 8:51 P T: 06/01/2002 9:05 A

cc: Eric R Powers, M.D.
Box 800662
Charlottesville VA 22908

Lynn Smith, M.D.
Rt 2 Box 171
Lewisburg WV 24901

OFFICE COPY FOR: Lynn Smith, M.D., DICTATED BUT NOT READ

Page 2 of 2

283
App.000547

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
ENDOSCOPY REPORT

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Date of Endoscopy: 05/23/2002

Physician: M Khalouck Abdrabbo, M.D.
Attending: M Khalouck Abdrabbo, M.D.

PREOPERATIVE DIAGNOSIS: Gastrointestinal bleeding.

POSTOPERATIVE DIAGNOSIS: Incomplete colonoscopy secondary to suboptimal prep, however, no active bleeding or source of blood loss identified.

PROCEDURE PERFORMED: Incomplete colonoscopy.

MEDICATIONS: Versed drip and fentanyl drip.

INSTRUMENT: CF-140L colonoscope.

DESCRIPTION OF PROCEDURE: A description of the procedure including its risks, benefits, complications, and alternatives to the procedure were explained to the patient's family member and informed consent obtained. The patient was then placed in the left lateral decubitus position while intubated in the CCU. Conscious sedation was administered via a versed and fentanyl continuous drip. Vital signs including heart rate, blood pressure, respiratory rate, and oxygen saturations were monitored throughout the procedure. Digital rectal exam revealed liquid stool on the glove, however, no blood or melena noted. Colonoscope was then inserted through the anus and advanced to the transverse colon and further advancement was limited secondary to suboptimal prep. Despite multiple flushings and aggressive suctioning, we were unable to clear a sufficient amount of stool to safely continue with the exam. At that point, the colonoscope was then withdrawn examining the colon as we came back to the level of the rectum. No active bleeding source or old blood was identified in the colon. No large, obstructing mass lesions were identified, although smaller lesions may have been missed secondary to the patient's suboptimal prep. Multiple diverticula were noted in the left colon, otherwise unremarkable exam.

IMPRESSION: Suboptimal prep due to retained liquid stool throughout the colon. Unable to advance the colonoscope beyond the hepatic flexure given poor quality of prep. No active bleeding or source of blood loss identified on exam.

S

UNIVERSITY OF VIRGINIA
Charlottesville, Virginia
Health System
ENDOSCOPY REPORT

Name: Fitzwater, Jackie Lee
Med Rec: 120-44-22
Date of Endoscopy: 05/23/2002

RECOMMENDATIONS: 1. Monitor for further bleeding and supportive care as indicated. 2. Further recommendations per DHSC consultation team.

M. Khalouck Abdrabbo, M.D. was present throughout the procedure.

Dictated and Dated by:

Michael K Sanders, M.D.
Fellow
Internal Medicine

Signed and Dated by:

M Khalouck Abdrabbo, M.D.
Attending
Internal Medicine

MS/tra Job: 000014990 D: 05/28/2002 8:51 P T: 06/01/2002 9:05 A

cc: Eric R Powers, M.D.
Box 800662
Charlottesville VA 22908

Lynn Smith, M.D.
Rt 2 Box 171
Lewisburg WV 24901

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 65 SEX: M
ACCT: D00098208363 LOC: D.309 B
EXAM DATE: 07/18/2001 STATUS: DIS IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000244948 COLON BARIUM ENEMA AIR CONT

AIR CONTRAST BARIUM ENEMA

The study is somewhat limited due to extensive tortuosity and redundancy of colon.

No evidence for obstruction. Scattered diverticuli, particularly descending-sigmoid colon. There is a filling defect seen on two images in the proximal transverse colon.

IMPRESSION:

1. DIVERTICULOSIS
2. FOCAL ROUNDED FILLING DEFECT EITHER REPRESENTING GAS BUBBLE OR SESSILE POLYP IN THE PROXIMAL TRANSVERSE COLON
3. STUDY IS SOMEWHAT LIMITED BY SIGNIFICANT TORTUOSITY, REDUNDANCY AND OVERLAP OF COLON
4. PROSTATIC CALCIFICATION SEEN

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT: TAPE 1

** Electronically Signed by David C Maki D.O. on 07/19/2001 at 0828 **
Reported and Signed by: David C Maki, D.O.

CC: Lynn Smith, M.D.

DICTATED DATE/TIME: 07/18/2001 (0947)
TECHNOLOGIST: Joan H Teubert RT(R)
TRANSCRIBED DATE/TIME: 07/18/2001 (2226)
TRANSCRIPTIONIST: PMTWJC
PRINTED DATE/TIME: 07/19/2001 (0836) BATCH NO: 5712

PAGE 1

Lynn Smith, M.D.

RECEIVED JUL 19 2001

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Jones, Ray
DOB: 04/25/1936 AGE: 65 SEX: M
ACCT: D00098219270 LOC: DRD
EXAM DATE: 09/25/2001 STATUS: REG CLI
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000255978 ESOPHAGUS (BA SWALLOW),
000255979 GI UPPER SERIES W/AIR CONTRAST

ESOPHAGRAM. UPPER GI SERIES.
CLINICAL HISTORY: DYSPHAGIA.

This study was performed with rapid sequence imaging over the pharynx and upper esophagus. There was a small amount of laryngeal penetration during the swallowing. The patient required a double swallow to clear and there was minor vallecular pooling. There was mild to moderate tertiary wave formation (esophageal discoordination) in the distal third of the esophagus. The stomach, duodenal cap and loop are normal.

IMPRESSION: ESOPHAGEAL DYSMOTILITY. ABNORMAL SWALLOWING MECHANISM.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT 1160

** Electronically Signed by Colin Rose M.D. on 09/25/2001 at 1314 **
Reported and Signed by: Colin Rose, M.D.

CC: Ray Jones, D.O.; Lynn Smith, M.D.

Dictated Date/Time: 09/25/2001 (0924)

Technologist: Gary L Mabry RT(R)

Transcribed Date/Time: 09/25/2001 (0944)

Transcriptionist: PMTJNM

Printed Date/Time: 09/25/2001 (1321) BATCH NO: 6021

PAGE 1

Lynn Smith, M.D.

Patient Name Jackie Fitzwater Age 69 Date 4/20/06 Lynn N. Smith, M.D.
 Chief Complaint Hosp 2016 C/O - Doris A. Ragsdale, M.D.
 John W. Galbreath, M.D.

Pertinent Past Medical History

Past Surgical History

Medications

JACKIE FITZWATER

4/20/2006

S: Mr. Fitzwater was hospitalized recently with a GI bleed. He had a hemoglobin of 7 with hematology and stools. He underwent both a ? and colonoscopy and one thing that was found was an erosive gastritis. He is helicobacter positive on biopsies. Hemoglobin is 9.6. We have started him back in anticoagulation. His pro time is now up to 2.2 INR. He is still on Lovenox therapy at home.

Review of Systems: Is really pretty good. He says his appetite is good, his weight is better. His ambulation has improved and his peripheral edema has stayed pretty constant. The weight has not

FAMILY HISTORY

PHYSICAL EXAM:

Ht 5'10" Wt 226 1/2 BP 102/48 Pulse 96 Temp 98.6 Resp 18
 EXAM LAB
 Normal Abnormal Comment AIC

changed. No change in his shortness of breath or PND or orthopnea. No chest pains. He has an ablation tear on his right arm that evidently occurred in the hospital that needs to be addressed. He still has his neuropathic findings in his legs, which are unchanged, but overall his activity level is improved according to he and his daughter.

EXAMINATION: His blood pressure is good at 108/70 with a pulse that is in the 70's. He has clear lung fields, no real rales or rhonchi. His valve click is unchanged, no new murmurs. He has no abdominal tenderness. He does have 1+ pitting edema bilaterally. His right arms shows about a 1 x 2 cm tear in the forearm around the elbow. It does not appear to be infected. It is clean and beginning to granulate.

IMPRESSION:

1. Recent GI bleed secondary to gastritis.
2. Anemia.
3. Prosthetic valve on chronic anticoagulation.
4. COPD.
5. Mild skin tear.

PLAN: We are going to put some Bactroban to the skin area and keep it covered for now. He is going to increase his Demadex back up to 100 twice a day after his Aldactone. Electrolytes were checked and are normal at this time. He is going to recheck his pro time in about 72 hour, continue the Lovenox until such time as he reaches therapeutic goals. We will have him follow up in approximately 2-3 ~~288~~ks.
 Lynn N Smith, MD/NM/aw

Patient Name Jackie Fitzwater Age 69 Date 4-4-06 . Lynn N. Smith, M.D.
 Chief Complaint 1 mo FLO - Doris A. Ragsdale, M.D.
 John W. Galbreath, M.D.

Pertinent Past Medical History _____

Past Surgical History _____

Medications _____

GENERAL

CARDIOVASCULAR

RESPIRATORY

GASTROINTESTINAL

Chest Pain _____

Sputum _____

Abd Pain _____

JACKIE FITZWATER

4/4/2006

S: Mr. Fitzwater is in for his monthly checkup and overall has done pretty well. His activity level has done better. His neuropathy has been better on the Lyrica. He still had quite a bit of peripheral edema and he did use some extra diuretics a little bit but he is pretty much on I think pretty well controlled at this time. The question also is to whether we are dealing with any worsening of his pulmonary HTN. He still gets a little dizzy at times when he gets up, but appetite has been good. No chest pains, palpitations, no syncope. He has not had any major changes in his legs and he thinks overall his neuropathy has improved.

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 216 1/2 BP 94/48 Pulse 92 Temp _____ Resp _____
 EXAM _____ LAB _____
 Normal _____ Abnormal _____ Comment 106/66 AIC _____

EXAMINATION: Blood pressure is about 98/60, but he goes up when he stands up. Pulse rate is unchanged. I hear no new murmurs or gallops. His lungs are clear at this time. He has his valve click, which is unchanged. He does still have about 1+ or a little more pitting edema bilaterally. Right leg is always worse than left. No Homans sign. His anticoagulation is therapeutic at 3.5.

IMPRESSION:

1. History of valvular heart disease s/p valve replacement.
2. History of restrictive cardiomyopathy.
3. Diabetes mellitus.
4. Pneumoconiosis.
5. Peripheral neuropathy.

PLAN: We will get an echo at this time to evaluate him for his pulmonary HTN. We will get his labs drawn at this time, but I am not going to make any major changes in his medicines until we get these results. Overall he is stable, but I think I would like to get his edema down a little bit better if possible. We will contact his daughter after we have the results in.

Lynn N Smith, MD/NM/aw

PLAN:

Patient Name Jackie Fitzwater Age 70 Date 7-28-06 Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.
John W. Galbreath, M.D.

Chief Complaint AV -

Pertinent Past Medical History

Past Surgical History

Medications

GENERAL

Wt Change _____
Fever _____
Chills _____
Sweats _____
HA _____
Weakness _____
Appetite _____

GENITOURINARY

Polyuria _____
Dysuria _____
Nocturia _____
Vag discharge _____
LMP _____

CARDIOVASCULAR

Chest Pain _____
SOB _____
Palpitation _____
Edema _____
HTN _____
PND _____
Orthopnea _____

MUSCULOSKELETAL

Arthralgia _____
Myalgia _____
Stiffness _____
Joint Swelling _____
Injury _____

RESPIRATORY

Sputum _____
DOE _____
Pleurisy _____
Cough _____
Hay Fever _____
Asthma _____
Hemoptysis _____

SOCIAL HISTORY

Smoking _____
ETOH _____
Diet _____
Exercise _____

GASTROINTESTINAL

Abd Pain _____
Diarrhea _____
Constipation _____
Melena _____
Pain _____

ENT

Sore Throat _____
Ear Ache _____
Visual Chgs _____
Vertigo _____
Rhinitis _____

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 219 BP 86/40 Pulse _____ Temp _____ Resp _____
EXAM Normal Abnormal Comment
LAB
A1C

JACKIE FITZWATER

7/28/2006

S: Mr. Fitzwater has had his colonoscopy, which did show some fairly large AVM's that were cauterized. None of them were actively bleeding. He says he feels pretty well at home. His last H&H done yesterday was down under 8 at 7.8. He does appear a little pale. Blood pressure is low at 86/40, but he is not asymptomatic with that. His peripheral edema has improved. Weight is down to 219 and his overall is about 1+ pitting edema.

IMPRESSION:

1. Anemia with persistent GI bleeding.
2. Prosthetic valve on chronic anticoagulation.
3. Cor pulmonale with pneumoconiosis.

PLAN: We are going to send him to the hospital for 2 units of blood transfusion. He should be able to go home the evening after that. He is scheduled to go back to see his GI doctor, hopefully have a capsule endoscopy. We will continue monitoring his counts on a regular basis, his weights and his renal function.

Lynn N Smith, MD/NM/aw

Patient Name Jackie Fitzwater Age _____ Date 10/6/06 Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.

Chief Complaint Hosp. f/up

JACKIE FITZWATER / **10/6/2006**

S: Mr. Fitzwater was hospitalized with an acute rectus sheath bleed. This basically was about a five to six unit bleed. He required transfusions. It was not due to an overall coagulopathy, but was most likely due to his Lovenox treatment that he was receiving at home during his urological surgery. He finally did stabilize and his numbers have improved. He was started back on his Coumadin because of his prosthetic valve. He has now just had a repeat pro time, which is elevated today at 4.4. He was 2.9 forty-eight hours ago, so obviously he has been re-anticoagulated. He has had no further active bleeding to the best of our knowledge. His counts have come up to 9.7. Renal function is stabilized at this time as well.

Review of Systems: His appetite is pretty good. He still has some early satiety symptoms, says he is just not as hungry. His blood pressure has been under good control. No fevers, chills or sweats. He denies any chest pains or palpitations. No PND or orthopnea. He has not had no cough or sputum production. He has had his recent microwave surgery for his prostate and his voiding seems to be improving from a urological standpoint. He has had no skin rashes. He still has large ecchymotic areas on his abdomen consistent with the recent bleed.

LMP _____ Injury _____ Knutius _____
FAMILY HISTORY _____ PT 25.5
PHYSICAL EXAM: INR 4.4
Ht _____ Wt 197.3 BP 112/46 Pulse 84 Temp _____ Resp _____
EXAM LAB
Normal Abnormal Comment AIC

EXAMINATION: Blood pressure is 112/50. His weight is down to 197 pounds. His lung fields are clear except his chronic changes at the right base. His valve click is the same with no new murmurs. He still has his grade 2 systolic murmur. He still has a large hematoma in his lower abdominal wall and quite a bit of ecchymotic areas, which is consistent with his resolving hematoma. He has trace peripheral edema, which is very good for him at this time. No new rashes.

His most recent labs showed his hemoglobin was 9.7. His creatinine was 1.5 with his BUN of 30, which is good for him.

IMPRESSION:

1. Recent rectus sheath bleed.
2. Anemia secondary to #1.
3. History of chronic GI blood loss due to AV malformation.
4. Diabetes mellitus.
5. Prosthetic valve on chronic anticoagulation.

PLAN: We are going to hold his Coumadin tonight and start him back on a 6 mg dose with a recheck in about four days. In two weeks he will return. We will also get a repeat on the CBC and basic metabolic panel at that time. No other change in his medicines pending those re-evaluations.

Lynn N Smith, MD/NM/aw

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 09/06/05

DISCHARGE DATE: 09/09/05

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSES:

1. Acute erosive gastritis with gastrointestinal bleed.
2. Anemia secondary to #1.
3. Iron deficiency secondary to chronic blood loss.
4. Diabetes, type 2.
5. Peripheral neuropathy.
6. Prosthetic valve replacement.
7. Hypothyroidism.
8. History of congestive heart failure.
9. Coumadin toxicity.

PROCEDURE:

1. Endoscopy of upper GI.

DISPOSITION: The patient is discharged home to the care of the family. He will be followed by Home Health Services. Pro time and hemoglobin will be checked on Sunday and on Tuesday, the following week. He will have a followup appointment in ten days. 1800 calorie, no added sodium diet, daily weights, O2 at 2 to 3 liters. Neurontin, 400 mgs daily, Flomax, .4, Nexium, 20 bid, Proscar, 5 mgs daily, Demadex, 100 mgs twice daily, Synthroid, .225 daily, Allopurinol, 100 mgs daily, Lanoxin, .125 daily, Lovenox, 100 mgs subcu twice a day until pro time is therapeutic, Glyburide, 5 mgs bid, Aldactone, 5 mgs a day, Coumadin, 6 mgs alternating 7 mgs, Ferrous Sulfate, one twice a day, Reglan prn, potassium 20 mEq bid. The patient will have stool for Helicobacter antigen drawn at this time.

SUMMARY: This is a 69 year old who was recently hospitalized with heart failure and ataxia, presented back with acute weakness after falling in the floor and unable to get up. He was so weak that he, even with the assistance of family, could not get up. No syncope, no pain, no palpitations, he just said he lost his balance and fell backwards. When he came to the emergency room workup done found him to be anemic with a hemoglobin of 7.6 with positive stools. His INR was elevated at 7. Normally is INR's are 3.5 to 4 because of his prosthetic valve and chronic anticoagulation.

HOSPITAL COURSE: He was admitted at this time, was given some fluid resuscitation and transfused two units of packed cells. His creatinine was 1.9 with a BUN of 62 consistent with some GI bleeding. We actually gave him 2.5 mgs of Vitamin K orally and watched his pro time improve. It did not return completely to normal, it did get down to the 1.9 range. Once it got subtherapeutic he was started on subcu Lovenox twice a day. He was seen in consultation by Dr. Jones. EGD was performed which did show evidence of an erosive gastritis which would be the etiology we think of the blood loss associated with his Coumadin toxicity. At this time he improved, his INR is still subtherapeutic on Lovenox, his hemoglobin is back up, he feels well, blood pressure is stable. His last hemoglobin was 9.2 at the time of his transfer. Overall he feels improved. We will send him home to continue with his current

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000039775

ADMISSION DATE: 09/06/05

DISCHARGE DATE: 09/09/05

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

therapy, try to get a Helicobacter antigen and see if this is the culprit and monitor
his H&H's serially.

Lynn N. Smith, M.D.

D: 09/17/05 0953

T: 09/18/05 0902

VMN

PMT, Inc., Job #8833

RECEIVED SEP 1 07 2005
ST. HUBERT

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE: 09/17/05
ATTENDING PHYSICIAN: Dr.

DOB: 04/25/36
DISCHARGE DATE: 09/17/05

UNIT #: D000038770

DISCHARGE DIAGNOSIS:

1. Ataxia believed secondary to multifactorial, possible onset of Parkinson's disease.
2. Severe peripheral neuropathy secondary to diabetes.
3. Status post prostatic valve.
4. Diabetes mellitus type 2.
5. Hypothyroidism.
6. History of gout.
7. History of restricted pericarditis.
8. History of congestive heart failure.

DISCHARGE INSTRUCTIONS: The patient will be on Sinemet 10/25 three times a day. BMP, BNP and his protime will be drawn on 09/07. Neurontin 400 mg daily, Potassium 20 mEq daily, Flomax 0.4 mg daily, Nexium 20 mg daily, Proscar 5 mg daily, Demadex 100 mg b.i.d., Reglan 10 mg p.o. t.i.d., Synthroid 0.225 mg daily, Allopurinol 100 mg daily, Lanoxin 0.125 mg daily, Glyburide 2.5 mg b.i.d., Aldactone 50 mg daily, Zaroxolyn 5 mg prn severe edema, Coumadin 6 mg alternating with 7 mg daily, iron tablets t.i.d., Vitamin C 500 mg b.i.d., Calcium vitamin supplementation. He will have a 1500 ml fluid restriction. The patient is discharged home and will followup with appointment in one week.

SUMMARY: This is a 69 year old with multiple medical problems who presented with increasing ataxia and difficulty in ambulation. He was tending to fall backwards. He was not able to walk and was running into walls and even falling off chairs. He almost fell off the exam table on two occasions while being examined. There was no history of any recent head traumas or injuries. No recent falls. The patient has a long standing history of multisystem disease as is outlined in his History and Physical.

PHYSICAL EXAM: On presentation, he had a very depressed affect. His blood pressure was 100/50 with a pulse of 90. He was in atrial fib with a controlled rate of 216. HEENT - Unremarkable. HEART - A grade II murmur was noted. He still had a valve click with no diastolic component. he had 1 to 2+ pitting edema chronically in his lower extremities. He had absent reflexes in his lower extremities. Decreased sensory to light touch. Motor tested pretty much normal at 4-5/5 motor strength at this time.

HOSPITAL COURSE: He was admitted and Cat scan of the head did not show any acute process. He was seen by Neurology Services who felt that again it was multifactorial. We were able to start him on some Sinemet to see if indeed he may have early Parkinson's disease. This also may just be due to his severe debilitated state and a severe peripheral neuropathy. He did have evidence of mild congestive failure, diastolic component. He was diuresed nicely. His weight came down to 200.

***** DISCHARGE SUMMARY *****

RECEIVED SEP 1 9 2005

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L
ADMISSION DATE: 09/17/05
ATTENDING PHYSICIAN: Dr.

DOB: 04/25/36
DISCHARGE DATE: 09/17/05

UNIT #: D000038770

His edema resolved. The patient was ambulating and eating and walking better with a walker at this time. He is discharged home in improved condition, although long term prognosis is guarded.

Lynn N. Smith, M.D.

D: 09/17/05 1005
T: 09/18/05 1059
VGC

PMT, INC. #08809

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.301

UNIT #: D000036770

ADMISSION DATE: 04/11/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

CHIEF COMPLAINT: Fatigue and weakness.

HISTORY OF PRESENT ILLNESS: This 69-year-old white male comes to the Emergency Department complaining of fatigue and weakness that have gotten gradually worse over the last month. He also states that he has been fairly short of breath and that he has had to increase his oxygen from 3 to 4 liters per minute. The family also tells met hat he has had significantly less PO food intake of late also. Investigations in the Emergency Department revealed heme positive stools and quite significant anemia with hemoglobin of 7.0 and hematocrit 23.6. Mr. Fitzwater has had history of GI bleed in the past. His most recent colonoscopy and EGD were in 03 and revealed severe gastritis and diverticulosis. He does have a prosthetic aortic valve and is on Coumadin therapy chronically. He does deny that he has had any dark stools or bright red blood per rectum.

ALLERGIES: NKDA.

PAST MEDICAL HISTORY: Significant for diabetes mellitus Type 2, prosthetic aortic valve, pacemaker, atrial fibrillation, COPD, BPH, colon polyps, diverticulosis, hypothyroidism, anemia, erosive gastritis.

PAST SURGICAL HISTORY: Aortic valve, cholecystectomy, appendectomy, pacemaker, pericardial window.

FAMILY HISTORY: Parents are both deceased. Mother died due to complications of diabetes. Father died from CHF. There is no cancer in the family to speak of.

SOCIAL HISTORY: The patient smoked half pack a day for the last 40 years. He is married to his wife of 50 years. He denies any significant drinking or drug use.

REVIEW OF SYSTEMS: The patient denies any fever, chills or night sweats. He does admit to fatigue and weakness as described above. He denies any trouble with his eyes or ears. He denies any speaking or swallowing difficulties. He denies any chest pain or palpitations. He does have a pacemaker. He admits to shortness of breath and dyspnea on exertion. He admits to history of GERD and gastritis. He denies any melena or bright red blood per rectum. He denies any nausea, vomiting, diarrhea or constipation. He denies any change in his bowel habits. He denies any urinary hesitancy, frequency or dysuria. He does admit to muscle weakness. He also admits to dependent edema, worse in the evenings and in the right leg greater than the left. He denies any problems with anxiety or depression.

PHYSICAL EXAMINATION: The patient is afebrile. Vital signs are stable. Blood pressure 110/59; temperature 97.0; pulse 81; respirations 20.

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

GENERAL: 69-year-old moderately obese white male who appears well built and well nourished in no acute distress.

HEENT: Head is normocephalic, atraumatic. Pupils are equal, round and reactive to light and accommodation. There is no jaundice or icterus of the sclera. Extraocular muscles are intact. Mucosal membranes are moist and pink.

NECK: Supple without JVD or masses. There is no thyromegaly.

CHEST: Equal expansion bilaterally. There is some scattered rhonchi throughout but good breath sounds. He does have some rib point tenderness on the angles of the 10th and 11th ribs on the posterior left side.

HEART: Regular rate and rhythm. There is a +3/6 systolic murmur and click associated with his prosthetic aortic valve.

ABDOMEN: Obese but soft, non-tender, positive bowel sounds.

GENITOURINARY: Deferred.

RECTAL: Hemoccult positive stool, also positive for external hemorrhoids.

EXTREMITIES: Lower extremities are puffy but there is no frank pitting edema. There are chronic vascular changes of the lower extremities. There is no clubbing or cyanosis noted. Pulses are +2/4 for all groups.

NEURO: Cranial nerves II thru XII grossly intact. Deep tendon reflexes +2/4 bilaterally.

LABORATORY EVALUATION: White blood cell 8.4; hemoglobin 7.0; hematocrit 23.6; platelets 293. Sodium 123; potassium 4.9; chloride 85; bicarb 32. BUN 42. Creatinine 1.9. Glucose 198. LFT's benign. INR 3.5. PTT 32.1. Digoxin 1.4. BNP 41.4. CK 18. Troponin 0.05. EKG showed the patient to be in atrial fibrillation without rapid response. There are no acute ST abnormalities.

ASSESSMENT:

1. Anemia.
2. GI bleed.
3. Atrial fibrillation.
4. Hyponatremia/hypochloremia.
5. Chronic renal failure.
6. Status post aortic valve replacement.
7. Diabetes mellitus Type 2.
8. COPD.
9. BPH.

RECEIVED APR 13 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L (Continued)
UNIT #: D000038770

PLAN:

Will admit the patient to third floor. We have typed and crossed for three units and will transfuse when he gets there. Consulted Dr. Jones from General Surgery to evaluate Mr. Fitzwater's GI bleed. For more information, see the orders.

Lynn N. Smith, M.D.

Dictated by J. Tabit, MS-IV

D: 04/11/06 1317
T: 04/11/06 1409
MAF
PMT, Inc. #00758
cc:

RECEIVED APR 13 2006

09/09/2005

Lynn Smith M.D.

Re: Jackie Fitzwater

Dear: Dr. Smith.

Thank you for referring Jackie Fitzwater to me for a EGD. The procedure was performed on 09/09/2005.

The indications for this examination were:

- Anemia

The patient tolerated the procedure well and there were no complications.

The endoscopic findings listed below were noted during today's procedure:

- The esophagus appeared normal.
- There was evidence of Grade II reflux esophagitis of the gastroesophageal junction. The mucosa appeared erythematous.
- There was evidence of erosive gastritis of the antrum. The mucosa appeared erosive and erythematous.
- The duodenum appeared normal.

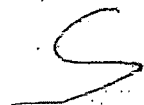
Based on the findings noted on today's examination and this patient's history I would recomend:

- None

Please find enclosed a copy of the report for your files. Thank you for an opportunity to assist in the care of this patient. Please feel free to contact me if I can be of further assistance to you. My office phone number is (304) 647-6023 or I can be reached via pager through my answering service at (304) 647-6023.

Sincerely,

Ray Jones D.O.



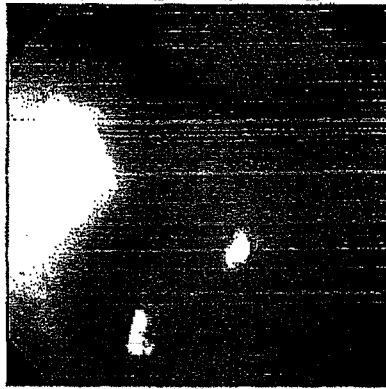
09/09/2005

Greenbrier Valley Med. Center

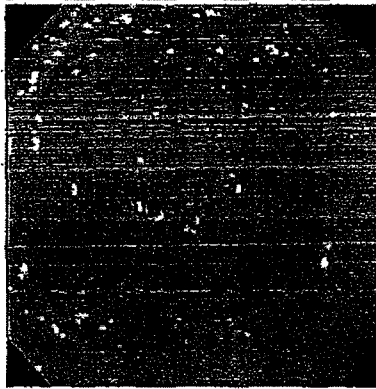
EGD Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 09/09/2005

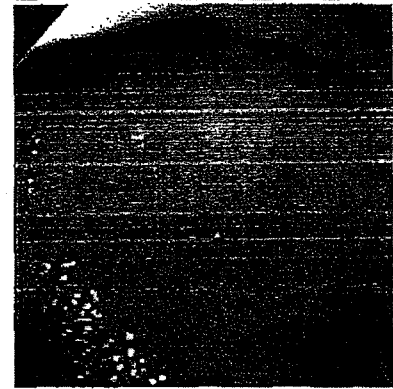
Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.



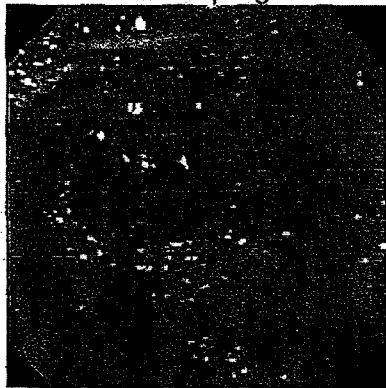
1 Esophagitis/Erythema
Distal Esophagus



2 Gastritis/Erosions
Antrum



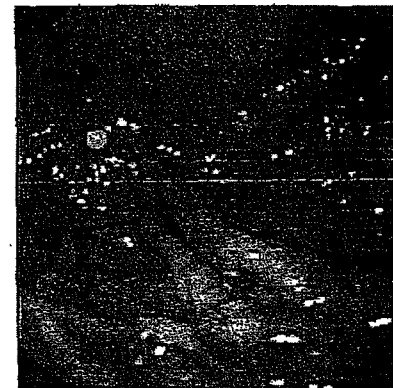
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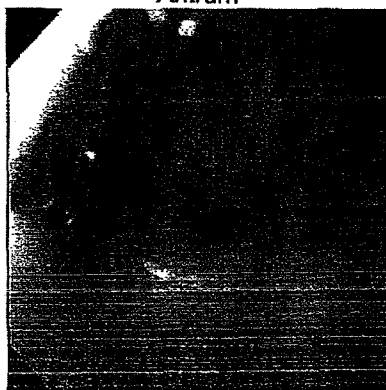
4
Antrum



5



6



7

INTRODUCTION:

69 year old male patient presents for an elective outpatient EGD. The indication for the procedure was anemia.

CLINICAL HISTORY & PHYSICAL EXAMINATION:

09/09/2005

Greenbrier Valley Med. Center**EGD Procedure Report**

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 09/09/2005

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.

The patient's clinical history and physical examination were performed and are documented in the patient's record.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:

- Versed 3 mg IV throughout the procedure
- Demerol 75 mg IV throughout the procedure
- benzocaine topically before the procedure

PROCEDURE:

The endoscope was passed without difficulty under direct visualization to the duodenum.

FINDINGS:

ESOPHAGUS: The esophagus appeared normal.

GE-JUNCTION: There was evidence of Grade II reflux esophagitis of the gastroesophageal junction. The mucosa appeared erythematous.

STOMACH: There was evidence of erosive gastritis of the antrum. The mucosa appeared erosive and erythematous.

DUODENUM: The duodenum appeared normal.

IMPRESSION:

1. The esophagus appeared normal.
2. Grade II reflux esophagitis of the gastroesophageal junction. [530.11].
3. Erosive gastritis of the antrum. [535.40].
4. The duodenum appeared normal.

PROCEDURE CODES:

43235: ESOPHAGOGASTRODUODENOSCOPY.

Ray Jones D.O.

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 08/30/05 DISCHARGE DATE: 09/03/05
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSES:

1. Congestive heart failure, primarily diastolic.
2. Restrictive pericarditis.
3. Ataxia, multifactorial.
4. Known prostatic valve.
5. Chronic atrial fibrillation.
6. Hypertension.
7. Hypothyroidism.
8. Pneumoconiosis.

DISCHARGE MEDICATIONS:

1. Sinemet 25/100 one 3 times a day.
2. Neurontin 400 mg daily.
3. KCl 20 mg daily.
4. Flomax .4 mg daily.
5. Nexium 20 mg daily.
6. Proscar 5 mg daily.
7. Demadex 100 mg b.i.d.
8. Reglan 10 mg t.i.d.
9. Synthroid .225 daily.
10. Allopurinol 100 mg daily.
11. Lanoxin .125 daily.
12. Glyburide 2.5 b.i.d.
13. Aldactone 50 b.i.d.
14. Zaroxolyn 5 mg 2 a day, if significant edema.
15. Coumadin 6 mg alternating with 7 mg daily.

The patient will continue on his other supplements with iron, vitamin C, and calcium.

Diet is a 1500 calorie with 1500 cc fluid restriction.

SUMMARY: This 69 year old presents with increasing shortness of breath, peripheral edema, and ataxia. He became much more weak and ataxic according to the family tending to fall backwards even into the wall. He had even fallen of chairs. He had a history of some gait disturbance due to known severe peripheral neuropathy in the past, but the question was whether this gentleman had now developed some new neurologic process. His shortness of breath and peripheral edema had markedly worsened and he gained weight significantly during this time frame with some increasing shortness of breath with dyspnea upon exertion. On presentation the patient was alert, he was very depressed affect, I was concerned that he just felt so bad that his blood pressure was 100/50, his pulses in the 90's irregular, his weight was 216. He had a grade II murmur with valve clicking which is unchanged. His abdomen was protuberant, no fluid wave. He had 1 to 2+ pitting edema with chronic stasis change and a small ulcer on the left lower leg. Neurologically his motor test

***** DISCHARGE SUMMARY *****

RECEIVED SEP 26 2005

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L DOB: 04/25/36 UNIT #: D000038770
ADMISSION DATE: 08/30/05 DISCHARGE DATE: 09/03/05
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

did pretty good, about 4/5 motor strength, but the patient was ataxic. He tended to fall off the exam table, he tended to fall backwards, he did not have nystagmus or truncal ataxia at the time.

The patient was admitted, had a CT of his head which showed no acute change, we aggressively diuresed him with IV diuretics. This resulted in a significant improvement in peripheral edema, shortness of breath, and his dyspnea. He was seen by neurology services and it was really kind of unclear what this etiology was. Because of some rigidity complaints, they thought it might be early Parkinson's disease and they subsequently started him on Sinemet. They also felt that it was multifactorial associated with his diabetes, his neuropathy, and his generalized motor weakness. At this time, he is ambulating much better, shortness of breath is improved, he is eating well, does not have any major new symptoms, and most of his failure has pretty well cleared at this time. He is going to be discharged to home in improved condition, follow up as an outpatient in approximately 1 week.

Lynn N. Smith, M.D.

D: 09/24/05 0838
T: 09/25/05 0719
SRS
PMT, Inc. Job #: 10670
cc:

RECEIVED SEP 26 2005

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.301

UNIT #: D000038770

ADMISSION DATE: 05/18/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: This is a 70 year old white multi-system disease. He began having episodes this morning of nausea and vomiting. The first one they thought was black, almost like coffeeground-type material but he really has not had much come up since then. He has been on iron therapy and they thought that might have been a factor. Stools have been black. He's had a recent hospitalization, again with a GI bleed due to erosive gastritis. He just finished a two week course of Prev-pak because of his Helicobacter. Hemoglobin had been running in the 8-9 range, predominantly almost 9 on a constant basis during this timeframe. He got weak, dizzy, more fatigued and was brought in the emergency room with these complaints.

PAST MEDICAL HISTORY: He has known type-2 diabetes, on oral agents. He has a prosthetic aortic valve, he has a permanent pacemaker, he has black lung, BPH, diverticular disease, hypothyroidism, history of erosive gastritis and anemia secondary to such. He's also had two episodes of sepsis including a toxic shock syndrome due to a cellulitis that resulted in renal failure and transient dialysis.

PAST SURGICAL HISTORY: He's had an aortic valve replacement due to rheumatic valve disease. Cholecystectomy. Appendectomy. Pacemaker. Pericardial window due to restricted pericarditis postoperatively.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS: Listed, they are numerous and are noted on his drug list.

FAMILY HISTORY: Both parents are deceased. His mother died due to diabetes. His father died of heart failure. There is no history of premature coronary disease or other malignancies within the family.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He does have a history of smoking. This gentleman stoked up to probably within the last year or two intermittently. He had a longstanding history of smoking at least a pack a day for 30 years and quit a number of years ago but still to my knowledge is still smoking occasionally. No significant alcohol.

REVIEW OF SYSTEMS: His appetite has been good, weight has been stable, no fever, chills or sweats. He has no difficulty in swallowing, hearing or vision. Chest, no cough, sputum or pleurisy. He's had the nausea and vomiting, has not had any gross bleeding that we're aware of, he has not had any hematochezia or hematemesis. No abdominal pain. No dysuria, frequency or hesitancy. He has BPH with mild outlet obstruction, he's on two medicines. He has musculoskeletal complaints of his knees, back and hips. He's noted some peripheral disease and swelling intermittently. He has known severe peripheral neuropathy in his feet, both in post inflammatory and

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

diabetic in nature.

PHYSICAL EXAM: He's alert and oriented at this time. He is not orthostatic, he was earlier but with fluid resuscitation pulse rate is in the 80's and he's no longer orthostatic at this time. The skin shows chronic changes of his distal extremities due to chronic stasis. No other lesions, no adenopathy. Pupils are equal and reactive. Sclera and conjunctiva are unremarkable. He has clear posterior pharynx. Good carotid upstrokes. Minimal bruit on the right. Lung fields are clear. He has an irregular rhythm with a Grade-II murmur at his valve click which is unchanged. Abdomen is obese. Bowel sounds are active. No organomegaly, tenderness or bruits. He has heme positive stool that is black. Extremities are warm, trace peripheral edema, chronic stasis changes. Neurologically he is alert and oriented, no neurological findings at this time. He has no focal change. Motor strength is good. He is able to stand at bedside.

LABORATORY: He is still mildly hyponatremic. Sodium is 128. BUN 60. Creatinine 2. INR is therapeutic at 3.2. Hemoglobin is down to 8 at this time. Blood sugar is 176. Potassium is minimally elevated at 5.7. EKG shows no other acute change. Chest x-ray shows chronic loculated right effusion.

IMPRESSION:

1. Probable recurrent GI bleed
2. Prosthetic valve with chronic anticoagulation
3. Electrolyte disturbance
4. Renal insufficiency
5. Diabetes mellitus
6. Restrictive pericarditis
7. Black lung disease

PLAN: Will admit him at this time. Put him on clear liquids and symptom control. Will monitor his H&H, if it continues to drop he may need transfusions and he's advised of that at this time.

Lynn N. Smith, M. D.

D: 05/19/06 0830
T: 05/19/06 0904
WJC

PMT, Inc. Job #: 11338

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 04/11/06

DISCHARGE DATE: 04/15/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. GI bleed believed secondary to erosive gastritis.
2. Anemia blood loss.
3. Prosthetic heart valve with chronic anticoagulation therapy.
4. History of restrictive pericarditis.
5. Diabetes mellitus type 2.
6. Severe peripheral neuropathy.
7. Mild renal insufficiency.
8. Chronic obstructive pulmonary disease.
9. History of congestive heart failure; diastolic in origin.

DISPOSITION: The patient is discharged home at this time and will restart his Coumadin tonight and will be placed on Lovenox subcu. q. 12 hours until such time as his protimes are therapeutic. He will be monitored by Home Health agencies who will start following him at home with checking his protimes and H & Hs. He will be followed in the office in approximately one week.

DISCHARGE MEDICATIONS: Oxygen 2 liters as needed, nebulizer with Albuterol and Atrovent, 2 to 3 times per day, Nexium 20 mg b.i.d., Glyburide 5 mg t.i.d., Levothyroid 225 mg daily, Demadex 100 mg in the morning and Lanoxin 0.125 mg daily, Allopurinol 100 mg daily, Proscar 5 mg a day, Flomax 0.4 mg twice a day, Aldactone 50 mg b.i.d. He will be on iron supplementation three times a day.

SUMMARY: This is a 69 year old gentleman with a history of chronic anticoagulation due to a prosthetic valve. He presented with increasing weakness and shortness of breath and was found to have a hemoglobin of 7. His previous ones 3-4 months ago had been in the 9 1/2 to 10 1/2 range which is about normal for him. He had no chest pain. He had increasing shortness of breath and weakness during that time frame. On evaluation, his electrolytes were unremarkable except for a mild decreased sodium. Potassium was adequate. His creatinine was up slightly in that he had a creatinine of 1.9 on presentation which did drop to below 1.6 prior to his discharge. His sugars remained in relative control anywhere from the 80s to 300 range with sliding scale, although we did hold his oral meds during this time frame. His coags were therapeutic with an INR of 3.5 and his Coumadin was placed on hold. Troponin was normal. Lovenox level was 1.4.

HOSPITAL COURSE: He was admitted and transfused a total of 4 units of packed cells. Ultimately, his hemoglobin was 9.7 prior to his discharge. He was placed on Lovenox and we withheld his Coumadin. Stools did remain mildly positive, but there was no evidence of any active aggressive bleeding. He was hydrated with some mild fluid resuscitation. He was seen in consultation by Dr. Jones and after his INR came back into a therapeutic range, he subsequently underwent both EGD and colonoscopy. He had evidence of an erosive gastritis with minimal esophagitis. No major issues in the

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 04/11/06

DISCHARGE DATE: 04/15/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

colon were found. He had some diverticular disease and some mild AV malformations, none of which had shown active bleeding. He tolerated his treatment well. His blood pressure remained stable. His ambulatory O2 sats were good. At this time, he was discharged home. We will wait for biopsies on his gastric evaluation and subsequently reanticoagulated with Coumadin as necessary because of his prosthetic valve.

Lynn N. Smith, D.O.

D: 04/16/06 0843

T: 04/17/06 1233

VGC

PMT, INC. #02148

***** DISCHARGE SUMMARY *****

Greenbrier Valley Med. Center

Colonoscopy with Non-Biopsy Instructions

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 04/15/2006

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.

The findings for your procedure include:

- Moderate internal and external hemorrhoids were present.
- There were numerous medium scattered diverticula present in the sigmoid and the descending colon.
- There were multiple small collections of small vessels in the transverse colon which showed no stigmata of recent hemorrhage.

Do not eat or drink for one and one-half (1-1/2) hours after the completion of the procedure. Start with only small sips of water. If small sips of water are tolerated, you may begin to take solid foods.

Because medications provided during the procedure may cause drowsiness, weakness and lack of coordination, DO NOT operate motorized vehicles, use dangerous equipment such as power tools, mowers, etc., and do not conduct important business or sign any legal documents until the following day after the procedure.

In order to prevent complications, please follow these precautionary instructions:

If you experience redness or swelling at locations where medications were given, place a warm wet washcloth over the affected area for twenty minutes at a time, until the locations redness or swelling subsides. If symptoms continue for 2-3 days, please call Outpatient Surgery at 304-647-6537 or the Emergency Room at 304-647-6080.

If you experience bleeding from the rectum, or have dark bowel movements, please contact your physician.

If you are persistently nauseous, experience vomiting, abdominal pain, fainting, black stool, or passage of blood in the stool in addition to vomiting, please contact your physician immediately.

If your temperature increases greater than 101 degrees, call your physician.

Avoid aspirin, Anacin, Bufferin, Alka Seltzer or any medication containing aspirin for one week. If needed, you may take Tylenol or Datril.

You may contact the Endoscopy Lab at 304-647-6023.

Ray Jones D.O.

RECEIVED APR 18 2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 04/15/2006

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.



1 Diverticulosis
Mid-Sigmoid



2 Vasc Malform/Fern-Like
Proximal Transverse



3
Cecum



4



5



6
Rectum

INTRODUCTION:

69 year old male patient presents for an elective outpatient colonoscopy. The indication for the procedure was anemia.

CLINICAL HISTORY & PHYSICAL EXAMINATION:

The patient's clinical history and physical examination were performed and are documented in the patient's record.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:

- Versed 5 mg IV throughout the procedure
- Demerol 100 mg IV throughout the procedure

PROCEDURE:

Rectal exam: Moderate internal and external hemorrhoids were present.

The endoscope was passed with a moderate amount of difficulty under direct visualization to the cecum confirmed by landmarks and

04/15/2006

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Greenbrier Valley Med. Center**Colonoscopy Procedure Report**

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 04/15/2006

Attending Physician: Ray Jones D.O.
Referring Physician: Lynn Smith M.D.

transillumination. The quality of the preparation was good.

FINDINGS: There were numerous medium scattered diverticula present in the sigmoid and the descending colon. There were multiple small collections of small vessels in the transverse colon which showed no stigmata of recent hemorrhage.

IMPRESSION:

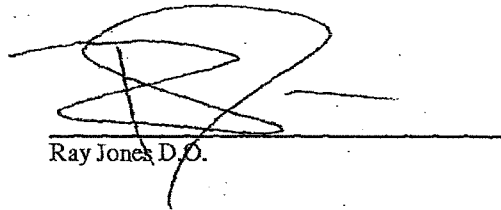
1. Moderate internal and external hemorrhoids [455.0].
2. Numerous medium scattered diverticula in the sigmoid and the descending colon. [562.10].
3. Vascular abnormality in the transverse colon. [747.61].

RECOMMENDATION:

- High fiber diet.

PROCEDURE CODES:

45378: COLONOSCOPY TO CECUM.



Ray Jones D.O.

RECEIVED APR 18 2006

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: UNIT #: D000038770
ADMISSION DATE: 07/28/06
ATTENDING PHYSICIAN: Dr. Lynn W. Smith

OBSERVATION NOTE

DATE: 7/28/06

This 70-year-old male has a history of chronic recurrent GI bleeding believed due to small bowel AVM's. He is on chronic anticoagulation due to prosthetic valve. He has had problems with progressive anemia because of this. Recent colonoscopy was done a couple of days ago and he is scheduled for further small bowel workup on out-patient basis. His labs yesterday showed his hemoglobin was down to 7.8. Blood pressure was running 86/40 in the office but he was not clinically symptomatic. He has been aggressively diuresed because of right-sided failure.

PAST MEDICAL HISTORY: He has cor pulmonale, pneumoconiosis, renal insufficiency, peripheral neuropathy, diabetes Type 2, history of restrictive pericarditis. He is status post mechanical valve, history of recurrent GI bleeding. Hypothyroidism and known chronic ataxia with cerebellar dysfunction.

CURRENT EXAM: He is alert, oriented. He is not in any acute distress. He actually feels pretty good at this time. Weight down to 219. BP 86/40. He has multiple ecchymotic areas on his arms consistent with his chronic anticoagulation. HEENT was otherwise unremarkable. Lung fields were clear. Cardiac shows regular rhythm. He has Grade II to III murmur systolic of aortic origin, no diastolic component, no gallops noted. Abdomen is obese. Bowel sounds are active. He has trace to 1+ pitting edema which is significantly improved, chronic dermatitis changes on his extremities.

IMPRESSION:

1. Blood loss anemia.
2. Severe cor pulmonale with pneumoconiosis.

RECEIVED AUG 9 2 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN:

He is admitted to observation. Will get two units of packed cells at this time. Once he completes, he will go home and will have a repeat on his labs on Monday by Home Health Services.

Lynn N. Smith, M.D.

D: 07/28/06 1211
T: 07/28/06 1317
MAF
PMT, Inc. #29663
cc:

RECEIVED AUG 02 2006

07/24/2006

Lynn Smith M.D.

Re: Jackie Fitzwater

Dear: Dr. Smith,

Thank you for referring Jackie Fitzwater to me for a Colonoscopy. The procedure was performed on 07/24/2006.

The indications for this examination were:

- Iron deficiency anemia

The patient tolerated the procedure well and there were no complications.

The endoscopic findings listed below were noted during today's procedure:


- There were multiple medium scattered diverticula present in the sigmoid and the descending colon.
- There were multiple medium collections of small vessels in the transverse colon, the ascending colon and the cecum which showed blood staining of the area. Bleeding control was performed, the post procedural endoscopic appearances were satisfactory.
- Multiple small non-bleeding, sessile polyps were seen in the sigmoid and the rectum which showed no stigmata of recent hemorrhage. Four polyps were removed by cold snare. The polyp was removed by cold biopsy forceps.
- Small non-bleeding internal hemorrhoids were present.

Based on the findings noted on today's examination and this patient's history I would recommend:

- Follow-up on the results of biopsy specimens as scheduled.
- High fiber diet.

Please find enclosed a copy of the report for your files. Thank you for an opportunity to assist in the care of this patient. Please feel free to contact me if I can be of further assistance to you. My office phone number is (304) 647-6023 or I can be reached via pager through my answering service at (304) 647-6023.

Sincerely,


Adedayo Mokuolu M.D.

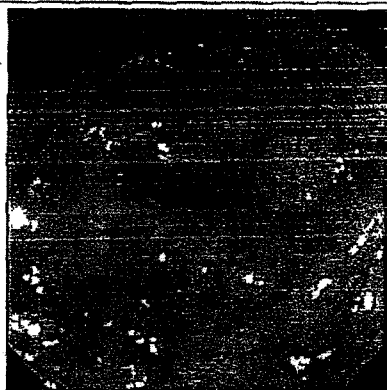
07/24/2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

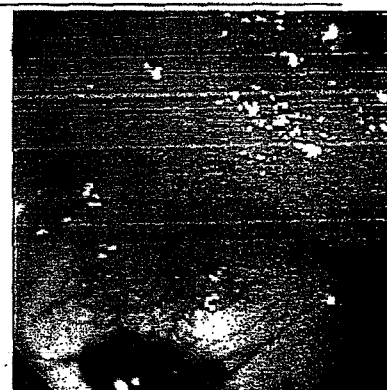
Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.



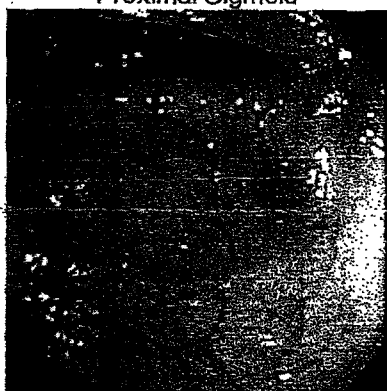
1 Diverticulum
Proximal Sigmoid



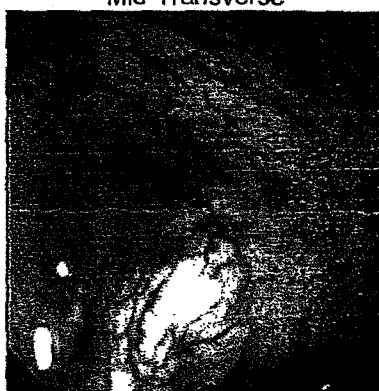
2 Vasc Malform/Fern-Like
Mid-Transverse



3 Vasc Malform/Fern-Like
Distal Ascending



4 Vasc Malform/Fern-Like
Distal Ascending



5 Vasc Malform/Fern-Like
Cecum



6 appendiceal orifice
Cecum



7 Vasc Malform/Fern-Like
Cecum



8 appendiceal orifice
Cecum



9 normal ileocecal valve
Proximal Ascending

07/24/2006

Greenbrier Valley Med. Center

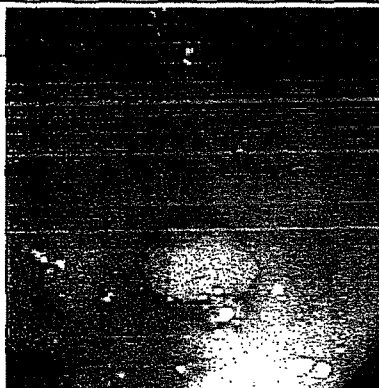
Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.



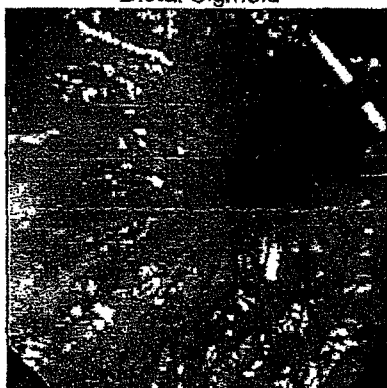
10 Sessile Polyp
Distal Sigmoid



11 Polyp
Distal Sigmoid



12 Sessile Polyp
Distal Sigmoid



13 Internal Hemorrhoids
Rectum



14 Sessile Polyp
Rectum

INTRODUCTION:

70 year old male patient presents for an elective outpatient colonoscopy. The indication for the procedure was iron deficiency anemia.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained.

PREPARATION:

EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:

- Fentanyl 100 mcg IV throughout the procedure
- Versed 6 mg IV throughout the procedure

PROCEDURE:

The endoscope was passed without difficulty under direct visualization to the cecum confirmed by appendiceal orifice and ileocecal valve. Retroflexion was performed. The quality of the preparation was fair.

FINDINGS: There were multiple medium scattered diverticula present in the sigmoid and the descending colon. There were multiple medium collections of small vessels in the transverse colon, the ascending colon and the cecum which showed blood staining of the

07/24/2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.

area. Bleeding control was performed, a BICAP monopolar probe was applied into the arteriovenous malformation using a coagulation setting of 3. The post procedural endoscopic appearances were satisfactory. Multiple small non-bleeding, sessile polyps were seen in the sigmoid and the rectum which showed no stigmata of recent hemorrhage. Four polyps were removed by cold snare. The polyp was removed by cold biopsy forceps. Small non-bleeding internal hemorrhoids were present.

COMPLICATIONS:

There were no complications associated with the procedure.

IMPRESSION:

1. Multiple medium scattered diverticula in the sigmoid and the descending colon. [562.10].
2. Vascular abnormality in the transverse colon, the ascending colon and the cecum. [747.61]. Bleeding control was performed, the post procedural endoscopic appearances were satisfactory.
3. Multiple small non-bleeding, sessile polyps in the sigmoid and the rectum. [211.4]. Four polyps were removed by cold snare. The polyp was removed by cold biopsy forceps.
4. Small non-bleeding internal hemorrhoids [455.0].

RECOMMENDATION:

- Follow-up on the results of biopsy specimens as scheduled.
- High fiber diet.

PROCEDURE CODES:

45383: COLONOSCOPY TO CECUM AND ABLATION OF TUMOR
45380: COLONOSCOPY TO CECUM AND BIOPSY

Adedayo Mokuolu M.D.

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L DOB: 04/25/36
ROOM #: D.202 UNIT #: D000038770
ADMISSION DATE: 07/28/06
ATTENDING PHYSICIAN: Dr. Lynn N. Smith

OBSERVATION NOTE

DATE: 7/28/06

This 70-year-old male has a history of chronic recurrent GI bleeding believed due to small bowel AVM's. He is on chronic anticoagulation due to prosthetic valve. He has had problems with progressive anemia because of this. Recent colonoscopy was done a couple of days ago and he is scheduled for further small bowel workup on out-patient basis. His labs yesterday showed his hemoglobin was down to 7.8. Blood pressure was running 86/40 in the office but he was not clinically symptomatic. He has been aggressively diuresed because of right-sided failure.

PAST MEDICAL HISTORY: He has cor pulmonale, pneumoconiosis, renal insufficiency, peripheral neuropathy, diabetes Type 2, history of restrictive pericarditis. He is status post mechanical valve, history of recurrent GI bleeding. Hypothyroidism and known chronic ataxia with cerebellar dysfunction.

CURRENT EXAM: He is alert, oriented. He is not in any acute distress. He actually feels pretty good at this time. Weight down to 219. BP 86/40. He has multiple ecchymotic areas on his arms consistent with his chronic anticoagulation. HEENT was otherwise unremarkable. Lung fields were clear. Cardiac shows regular rhythm. He has Grade II to III murmur systolic of aortic origin, no diastolic component, no gallops noted. Abdomen is obese. Bowel sounds are active. He has trace to 1+ pitting edema which is significantly improved, chronic dermatitis changes on his extremities.

IMPRESSION:

1. Blood loss anemia.
2. Severe cor pulmonale with pneumoconiosis.

RECEIVED JUL 31 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN:

He is admitted to observation. Will get two units of packed cells at this time. Once he completes, he will go home and will have a repeat on his labs on Monday by Home Health Services.

Lynn N. Smith, M.D.

D: 07/28/06 1211
T: 07/28/06 1317
MAF
PMT, Inc. #29663
CC:

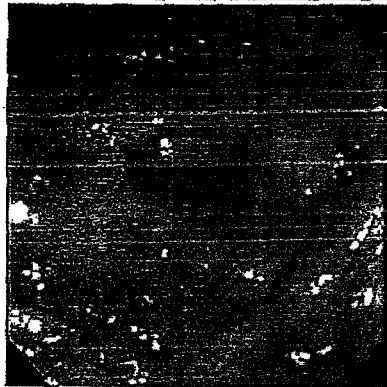
RECEIVED JUL 31 2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.



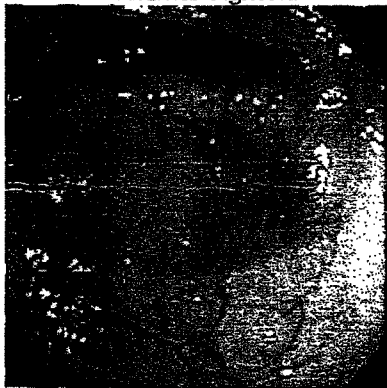
1 Diverticulum
Proximal Sigmoid



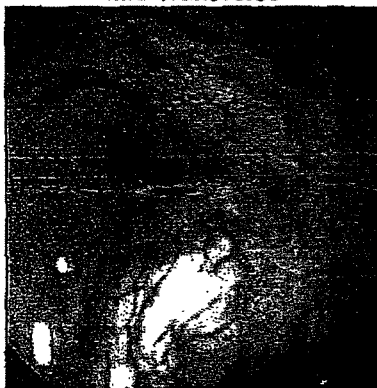
2 Vasc Malform/Fern-Like
Mid-Transverse



3 Vasc Malform/Fern-Like
Distal Ascending



4 Vasc Malform/Fern-Like
Distal Ascending



5 Vasc Malform/Fern-Like
Cecum



6 appendiceal orifice
Cecum



7 Vasc Malform/Fern-Like
Cecum



8 appendiceal orifice
Cecum



9 normal ileocecal valve
Proximal Ascending

07/24/2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.



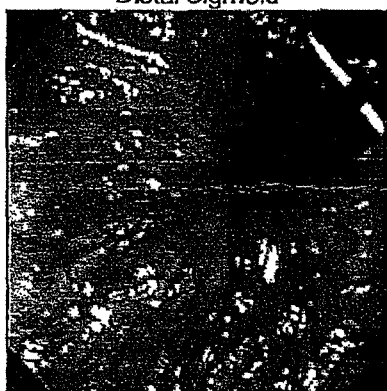
10 Sessile Polyp
Distal Sigmoid



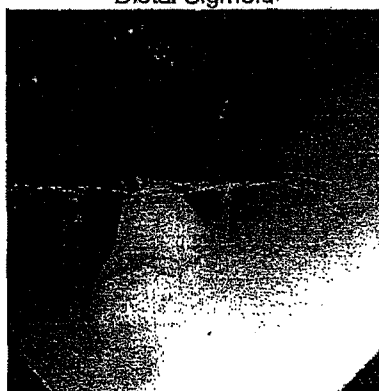
11 Polyp
Distal Sigmoid



12 Sessile Polyp
Distal Sigmoid



13 Internal Hemorrhoids
Rectum



14 Sessile Polyp
Rectum

INTRODUCTION:

70 year old male patient presents for an elective outpatient colonoscopy. The indication for the procedure was iron deficiency anemia.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained.

PREPARATION:

EKG, pulse, pulse oximetry and blood pressure monitored.

MEDICATIONS:

- Fentanyl 100 mcg IV throughout the procedure
- Versed 6 mg IV throughout the procedure

PROCEDURE:

The endoscope was passed without difficulty under direct visualization to the cecum confirmed by appendiceal orifice and ileocecal valve. Retroflexion was performed. The quality of the preparation was fair.

FINDINGS: There were multiple medium scattered diverticula present in the sigmoid and the descending colon. There were multiple medium collections of small vessels in the transverse colon, the ascending colon and the cecum which showed blood staining of the

07/24/2006

Greenbrier Valley Med. Center

Colonoscopy Procedure Report

Patient: Jackie Fitzwater
Patient ID: 038770
Exam Date: 07/24/2006

Attending Physician: Adedayo Mokuolu M.D.
Referring Physician: Lynn Smith M.D.

area. Bleeding control was performed, a BICAP monopolar probe was applied into the arteriovenous malformation using a coagulation-setting of 3. The post procedural endoscopic appearances were satisfactory. Multiple small non-bleeding, sessile polyps were seen in the sigmoid and the rectum which showed no stigmata of recent hemorrhage. Four polyps were removed by cold snare. The polyp was removed by cold biopsy forceps. Small non-bleeding internal hemorrhoids were present.

COMPLICATIONS:

There were no complications associated with the procedure.

IMPRESSION:

1. Multiple medium scattered diverticula in the sigmoid and the descending colon. [562.10].
2. Vascular abnormality in the transverse colon, the ascending colon and the cecum. [747.61]. Bleeding control was performed, the post procedural endoscopic appearances were satisfactory.
3. Multiple small non-bleeding, sessile polyps in the sigmoid and the rectum. [211.4]. Four polyps were removed by cold snare. The polyp was removed by cold biopsy forceps.
4. Small non-bleeding internal hemorrhoids [455.0].

RECOMMENDATION:

- Follow-up on the results of biopsy specimens as scheduled.
- High fiber diet.

PROCEDURE CODES:

45383: COLONOSCOPY TO CECUM AND ABLATION OF TUMOR
45380: COLONOSCOPY TO CECUM AND BIOPSY.



Adedayo Mokuolu M.D.

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.200

UNIT #: D000038770

ADMISSION DATE: 08/24/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY: This 70 year old has a history of recurrent GI bleeds due to believed small bowel AVM's. He's just undergone a capsule endoscopy yesterday to try to identify the source. His last H&H 48 hours ago was down to 7.9. He has to be fully anticoagulated because of a prosthetic aortic valve. He was just recently at the University of Virginia for this evaluation and some adjustments were made in his medications because of his severe right sided heart failure.

PAST MEDICAL HISTORY: Renal insufficiency. Pneumoconiosis. Cor pulmonale. Diabetes type-2, on oral meds. He has a history of restrictive paracarditis. He has a history of recurrent GI bleeding. Known chronic ataxia with cerebellar dysfunction. He has had several episodes of sepsis due to cellulitis.

PAST SURGICAL HISTORY: Aortic valve replaced due to rheumatic heart disease. Appendectomy. Cholecystectomy. Pacemaker due to tachy-brady syndrome. A pericardial window was performed due to his restrictive paracarditis post valve replacement.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS: Listed.

REVIEW OF SYSTEMS: Unremarkable. His weight has been stable at about 230. He is eating well. No nausea, vomiting, diarrhea, chest pain, palpitations, PND. He has had increased weakness and some mild dyspnea now because of his progressive anemia. His peripheral edema has been better since coming home from the University of Virginia.

PHYSICAL EXAM: He's alert, he's oriented. Vital signs are pending. Skin is warm and dry. He has chronic stasis dermatitis of his legs. HEENT is unremarkable. Lung fields are clear. No rales except at the right base because of his known chronic effusion. He has Grade-II murmur with a valve click. He has 1+ pitting edema. Abdomen is less distended. He is sitting in a chair so I can't really be sure about the presence of ascites.

IMPRESSION:

1. Anemia with persistent GI bleed
2. Prosthetic aortic valve, on chronic anticoagulation
3. Cor pulmonale
4. Pneumoconiosis
5. Diabetes mellitus

RECEIVED AUG 25 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN: He is admitted at this time for three units transfusion. He is going to continue his current home meds. He will be treated with Benadryl at this time and can be released after his transfusions are completed.

Lynn N. Smith, M. D.

D: 08/24/06 0807
T: 08/24/06 1113
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PMT, Inc. Job #: 06455
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RECEIVED AUG 25 2006

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.331

UNIT #: D000038770

ADMISSION DATE: 09/15/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

HISTORY OF PRESENT ILLNESS: This 70 year old male has a history of multisystem problems. He recently had urological surgery with microwave surgery for BPH. This gentleman is on chronic anticoagulation because of a mechanical aortic valve due to rheumatic heart disease. As a result of this, his Warfarin therapy was discontinued and he was placed on outpatient Enoxaparin pre and post operatively. This surgery was performed without real complication. He was started back on his Coumadin within the process of getting anticoagulated back to the point of full therapeutic intervention. On Tuesday, he began to have some discomfort in his abdominal wall. He thought this was occurring after he had received one of his shots. This progressed to today. He began to have increasing weakness and significant pain in his lower abdominal wall and expanding mass that was palpable. Because of this, he was advised to come to the hospital for evaluation. He was found to have a large hematoma developing on his anterior abdominal wall. CT scan confirms that this is in the rectus sheath. There was no intra-abdominal bleeding identified. He has chronic ascites and right pleural effusion because of severe cor pulmonale and pulmonary hypertension. It appears that this was mostly a bleed. His Hgb had come down to 7.2. It had been 8.3 48 hours prior.

This gentleman has a history of recurrent bleeding due to AVM in the small bowel. He has undergone coagulation therapy and we had felt at this time that he had stabilized. His last 2 Hgbs had been 10 and 10.5 over the past several weeks. He had just recently been to UVA for evaluation of his right sided heart failure. He had undergone right heart cath and indeed had severe pulmonary hypertension. He had also just begun on therapy with low dose of Viagra at 20 mg tid for his pulmonary hypertension.

PAST MEDICAL HISTORY: He has a history of mild renal insufficiency, pneumoconiosis, cor pulmonale, type 2 diabetes on oral meds. He has had the recurrent Gi bleed secondary to bowel AVM. He has also had a history of restricted pericarditis, post valve replacement. He has had two episodes of toxic shock syndrome associated with Strep septicemia due to leg cellulitis.

PAST SURGICAL HISTORY: Permanent pacemaker due to tachy-brady syndrome, pericardial window and stripping has been performed. He has had a cholecystectomy, appendectomy, aortic valve replacement due to rheumatic heart disease.

ALLERGIES: No known allergies.

CURRENT MEDICATIONS: Please see those listed. They are fairly numerous and available in his record.

REVIEW OF SYSTEMS: He had actually been doing fairly well at home until recently.

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SEP 18 2006

324
App.000588

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

Appetite has been good. Weight has been stable. Fluid level has been controlled. He has had no difficulty in swallowing, hearing, or visual impairments. He had had minimal cough. He has had increasing shortness of breath in the past few days even to the point of having to use his portable O2 in the house according to family members. No cough or sputum production. No frank PND. He has had no chest pain, palpitations. No nausea, vomiting, diarrhea. He still has a foley catheter in place from his recent surgery and was anxious to see that being removed in the not too distant future. Extremities have shown increasing weakness believed due to his anemia. He had had very little peripheral edema and had been under much better control as of late on his current medical management. He had no significant skin changes. He had not seen any bruising at this time. He did not have any polyuria, polydipsia, or new skin lesions.

PHYSICAL EXAM: He is alert. He is complaining of some moderate pain of the abdominal wall. A very tender mass is palpable and reproduces his pain. His blood pressure is 118/80. O2 sat is 97%. His pulse is 80. He does have some ecchymotic areas on his arm which don't appear to be excessive. There is no flank or gluteal bruising at this time. HEENT - Pupils are equal and reactive. No scleral icterus. Posterior pharynx is clear. TMs are unremarkable. Good carotid upstrokes without audible bruits. Thyroid is not enlarged. Lungs showed decreased breath sounds at the right base with a known chronic pleural effusion. Abdomen does show large left sided rectus sheath mass consistent with hematoma. He has, probably, some mild ascites identified which is not unusual for him. He has no scrotal edema at this time. He has a foley catheter in place. Extremities are warm. He has trace peripheral edema, some chronic skin changes distally due to his chronic stasis dermatitis but no evidence of open lesions at this time. Neurologically, he is alert, oriented X 4. He moves all extremities well. Toes are downgoing with no focal motor abnormality.

INVESTIGATIONS: PT is therapeutic at 3.1. CMP shows sodium slightly low at 129. Sugar is 237 with BUN of 44 and creatinine of 1.4. LFTs are normal. Dig is 1.5. His CBC shows a Hgb of 7.2, platelet count is therapeutic at 166, WBC 5800. CT of the abdomen/pelvis shows the hematoma is identified with some mild ascites and chronic right pleural effusion with no other major abnormalities.

IMPRESSION:

1. Anemia, secondary to blood loss.
2. Rectus sheath bleed on Coumadin/Enoxaparin.
3. Mechanical aortic valve due to rheumatic fever.
4. Permanent pacemaker.
5. Diabetes mellitus.
6. Severe cor pulmonale with pulmonary hypertension.

RECEIVED SEP 18 2006

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P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

7. Pneumoconiosis.
8. History of renal insufficiency.

PLAN: At this time, we have stopped all anticoagulation. His Hgb is 7.2 and he will be transfused 3 units of packed cells. Ice pack will be placed on his abdominal wall and pain management. We will not aggressively reverse his Coumadin at this time. We will see if there is evidence of continued active bleeding at this time but we will hold all anticoagulation at this time. Obviously, risk is involved for potential embolic disease should he remain uncoagulated for an extended period of time. We would hope that with a 48 hour window, we will hopefully be able to decrease and stop his bleeding within this region. We will closely monitor his hemodynamically and H&H will be performed.

Lynn N. Smith, M.D.

D: 09/16/06 0305
T: 09/16/06 1205
DAS
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RECEIVED SEP 18 2006

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

CONSULTATION REPORT

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

DOB: 04/25/36
ROOM #: D.302

DATE OF CONSULTATION: 9/18/06.

ATTENDING PHYSICIAN: Lynn Smith, M.D.

CONSULTING PHYSICIAN: Joseph Mouchizadeh, M.D.

REASON FOR CONSULTATION: Jackie Fitzwater is a very pleasant 70 year old male who is well known to me. He was in the office last week and had an uncomplicated transurethral microwave thermotherapy. He was admitted here after developing a significant rectus hematoma.

MEDICATIONS: Include glyburide, Lasix, K-Lor, coumadin, Arevatan (?), Vitamin C, Lipitor, allopurinol, Synthroid, Nexium, Digitek, Zaroxolyn.

PAST MEDICAL HISTORY: Significant for TSS (toxic shock syndrome), gastrointestinal bleed, aortic valve replacement, mitral insufficiency and benign prostatic hypertrophy. I will not reiterate in great detail his history because this is all clearly delineated in multiple visits to the hospital.

RECOMMENDATIONS: I think that we can go ahead and remove his Foley catheter. The physical exam demonstrates a Foley catheter. Rectal exam was unchanged. I think we can go ahead and pull it out and see what happens. I will follow with you.

Thank you for the courtesy of this consultation.

Joseph Mouchizadeh, M.D.

D: 09/20/06 0726
T: 09/20/06 0928
JNM

cc: Dr. Lynn Smith

PMT, Inc. Job #: 13414

RECEIVED SEP 21 2006

GREENBRIER VALLEY MEDICAL CENTER

PO BOX 497

RONCEVERTE, WV 24970

(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 09/15/06

DISCHARGE DATE: 09/28/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Rectus sheath bleed secondary to chronic anticoagulation.
2. Mechanical prosthetic valve secondary to rheumatic heart disease.
3. Congestive heart failure, primary diastolic.
4. Permanent pacemaker secondary to heart block.
5. Chronic obstructive pulmonary disease with severe cor pulmonale and pulmonary hypertension.
6. Diabetes mellitus type 2 with severe peripheral neuropathy and early nephropathy.
7. Pneumoconiosis.

PROCEDURE: Portacath catheter placed.

DISPOSITION: The patient is discharged home to the care of the family. he will have daily weight, O2 at 2 to 3 liters per nasal cannula, 1500 calorie ADA no added sodium diet and up with walker. Home Health to follow protime q. 48 hours until stable. Coumadin 8 mg q. p.m., Lasix 120 mg PO b.i.d., Lortab 5/500 q. 6 h prn pain, Feosol one b.i.d. with meals, Glyburide 7.5 mg b.i.d., KCl one PO b.i.d., Lipitor 10 mg daily, Allopurinol 100 mg daily, Synthroid 0.2225 mg daily, Digoxin 0.125 mg daily, Zaroxolyn 5 mg daily. The patient will have a CBC and a BMP drawn in six days after discharge.

SUMMARY: This is a 70 year old gentleman who recently underwent microwave prostatic surgery due to BPH and outlet obstruction. Because of this, he was placed on Lovenox injections at home. Warfarin therapy was discontinued for his surgery. He had been started back on his Coumadin and was in the process of getting fully anticoagulated when he began having increased abdominal wall discomfort. He began having significant pain and increasing weakness. Because of this, he was brought to the hospital. He was found to be developing a very large hematoma in his left anterior abdominal wall. CT scan confirmed what was present, the rectus sheath bleed. He had known chronic ascites and right pleural effusion with severe cor pulmonale. Hemoglobin was down to 7.2 at the time of admission. he also has a history of recurrent bleeding secondary to AVMs of the small bowel and had undergone coagulation therapy and that had actually improved.

HOSPITAL COURSE: Mr. fitzwater was admitted. His anticoagulation was withheld and he was initially transfused 3 units of packed cells. Ice packs were placed on the abdominal wall with some mild compression bandages. Basically, we withheld his Coumadin, realizing that his protime would have to fall to a normal range. This gradually began to improve. He had quite a bit of pain initially requiring narcotics to control the pain due to the expanding hematoma. Protimes came back down to 2 and then subsequently into the 1 1/2 range. Bleeding scans were performed which did confirm actually multiple sites of bleeding within the rectus sheath initially. His blood pressure remained stabilized. His renal function stabilized. After we had

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
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(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 09/15/06

DISCHARGE DATE: 09/28/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

what we felt was adequate bleeding control and his hemoglobin stabilized, he was started back on IV Heparin without a bolus and just a continuous infusion. We were maintaining low level anticoagulation until such time as his Coumadin could be restarted. Basically, he stabilized. His hemoglobin began to come up spontaneously. He was able to have his catheter removed and voided well. The rectus sheath bleed was contained ultimately and began to resolve. He was converted back over to his oral medication and when his INR was 2.4, he was discharged home and was being monitored closely on an outpatient basis. Long term prognosis is still guarded due to the possible risk of recurrent bleed.

Lynn N. Smith, M.D.

D: 10/14/06 0922

T: 10/14/06 1345

VGC

PMT, INC. #20195

***** DISCHARGE SUMMARY *****

Dictating Physician's copy / STATUS: Draft

COLONOSCOPY REPORT

Greenbrier Valley Medical Center

DATE: January 20, 2000

ENDOSCOPIST: Diego Gomez M.D.

REFERRING PHYSICIAN: Lynn Smith MD

PATIENT NAME: Jackie L. Fitzwater

HOSPITAL NO: 038770

HISTORY/INDICATIONS:

This colonoscopy was performed for evaluation of occult blood in the stool, anemia.

INSTRUMENT: CF-100I

MEDICATIONS:

Preoperative: Demerol (meperidine) 75 mg IV

Versed (midazolam) 3 mg IV

BIOPSIES: yes

BRUSHINGS: no

PHOTOGRAPHS: yes

PROCEDURE:

A history and physical examination were performed. The procedure, indications, potential complications (bleeding, perforation, infection, adverse medication reaction), and alternatives available were explained to the patient who appeared to understand and indicated this.

Opportunity for questions was provided and informed consent obtained.

After placing the patient in the left lateral decubitus position, the colonoscope was inserted into the rectum and under direct visualization advanced to the cecum which was identified by identification of the appendiceal orifice, identification of the cecal strap (crow's foot)

Careful inspection was made as the colonoscope was withdrawn. The quality of the prep was good. The patient tolerated the procedure well. There were no complications.

FINDINGS:

- There were multiple sessile polyps ranging in size from 4 mm to 12 mm which were located throughout the colon. The hot biopsy forceps were used to biopsy/remove 1 polyp from the cecum and 8 polyps from the sigmoid colon. Inspection of the biopsy sites revealed adequate hemostasis. (Image 7) (Image 11)

- Frequent diverticular orifices were noted in the sigmoid colon. (Image 1)

- Other than the findings noted above, the visualized colonic segments were normal.

- Photodocumentation was obtained. (Image 3)

IMPRESSION:

- Multiple colonic polyps (biopsied/removed)

- Moderate Diverticulosis

RECOMMENDATIONS:

- Follow-up the biopsy results

- Continue present medication

- Upper GI barium contrast study with small bowel follow through

- Follow up with GI clinic when needed

Jackie L. Fitzwater
038770

Endoscopy Unit
Form No 111-589/Rev 7/89

Date: 01/20/00
Time: 13:18

330
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RECEIVED JAN 25 2001

ESOPHAGOGASTRODUODENOSCOPY REPORT

Greenbrier Valley Medical Center

DATE: January 19, 2000

ENDOSCOPIST: Diego Gomez M.D.

REFERRING PHYSICIAN: Lynn Smith MD

PATIENT NAME: Jackie L. Fitzwater

HOSPITAL NO: 038770

HISTORY/INDICATIONS:

This upper endoscopy was performed for evaluation of anemia, hematochezia.

INSTRUMENT: GIF-130**MEDICATIONS:** Demerol (meperidine) 75 mg IV
Versed (midazolam) 3 mg IV**BIOPSIES:** no**BRUSHINGS:** no**PHOTOGRAPHS:** yes**PROCEDURE:**

A history and physical examination were performed. The procedure, indications, potential complications (bleeding, perforation, infection, adverse medication reaction), and alternatives available were explained to the patient who appeared to understand and indicated this. Opportunity for questions was provided and informed consent obtained. The endoscope was passed through the incisoral orifice into the oral cavity and under direct visualization the esophagus was intubated. The endoscope was passed down the esophagus, through the stomach and into the duodenum. A careful inspection was made as the endoscope was withdrawn. The patient tolerated the procedure well and there were no complications.

FINDINGS:**ESOPHAGUS:**

- The esophagus was normal in appearance and there was no evidence of esophagitis, intrinsic mass, extrinsic compression, esophageal varices, ring, web, stricture, motor disturbance, Barrett's epithelium, diverticula, or bleeding.
- Photodocumentation was obtained (Image 4)

STOMACH:

- Mucosal abnormalities were noted in the antrum and prepyloric region and included patchy erythema. (Image 3)
- Other than the findings noted above, there were no other gastric abnormalities noted.
- Photodocumentation was obtained (Image 1)

DUODENUM:

- The endoscope was passed into the second portion of the duodenum. The duodenum was normal and there was no evidence of duodenitis, duodenal ulcers, nodules, diverticula, intrinsic, or extrinsic masses, polyps, arteriovenous malformations (AVM's), in the duodenum, duodenal bulb, or pylorus.
- Photodocumentation was obtained (Image 2)

IMPRESSION:

- Nonspecific gastritis

RECOMMENDATIONS:

- Colonoscopy within 24 hours

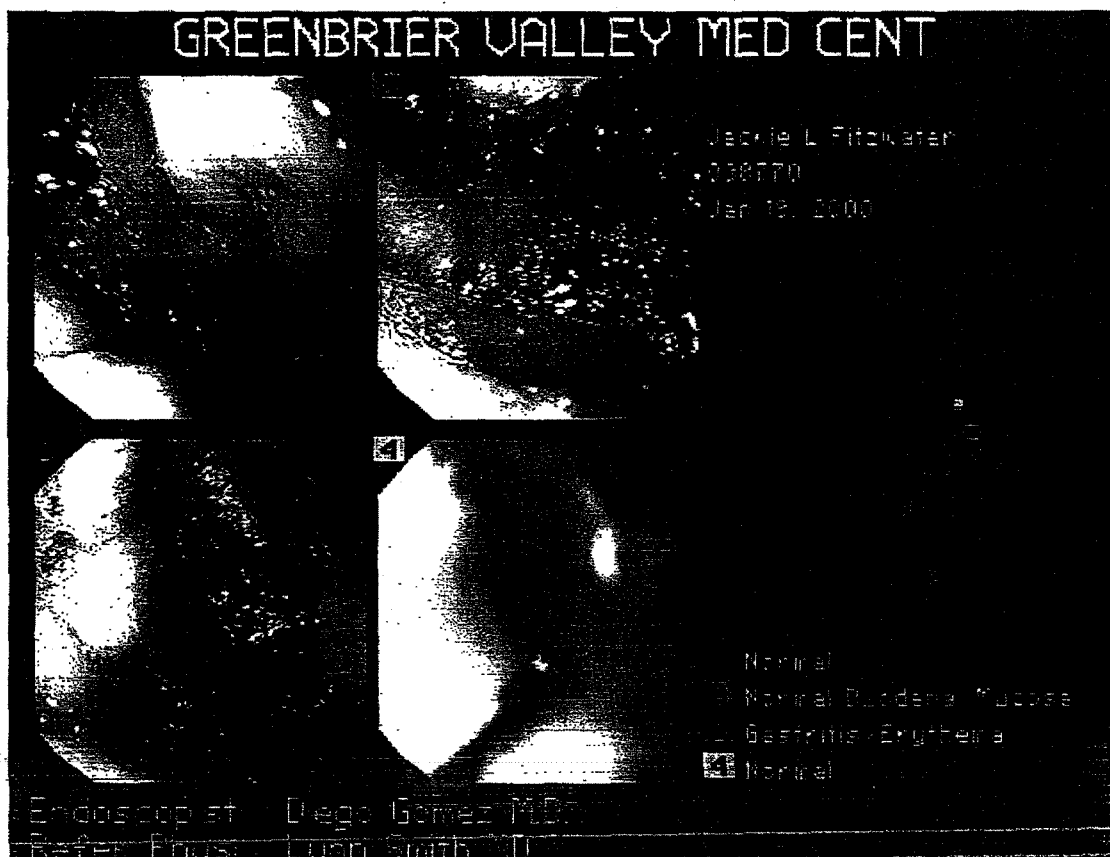
Jackie L. Fitzwater
038770Endoscopy Unit
Form No 111-589/Rev 7/89Date: 01/19/00
Time: 3:49:44
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ESOPHAGOGASTRODUODENOSCOPY REPORT

Greenbrier Valley Medical Center

- Continue present medication
- Observe in a hospital setting
- Repeat laboratory studies

Diego Gomez M.D.



Jackie L. Fitzwater
038770

Endoscopy Unit
Form No 111-589/Rev 7/89

Date: 01/19/00
Time: 09:44

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GREENBRIER VALLEY MEDICAL CENTER

P.O. BOX 497

RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.PCU

UNIT #: D000038770

ADMISSION DATE: 01/14/00

ATTENDING PHYSICIAN: Dr. Lynn Smith

PATIENT PROFILE: This is a 63 year old with a history of hypertension, aortic valve replacement because of a bicuspid aortic valve and chronic anticoagulation therapy.

CHIEF COMPLAINT: Weakness, falling.

HISTORY OF PRESENT ILLNESS: Mr. Fitzwater has evidently had two falls one of which appeared to be a frank syncopal episode on Monday. He was walking through the kitchen and suddenly just found himself on the floor. He has been very weak and has noticed some progressive weakness over the last several weeks. He denies any shortness of breath or any new chest pain. He has noted that he was staggering when he got up and would walk and has history of some significant underlying cardiac problems. He had an aortic valve replaced in December of 1998. It was a St. Jude's valve. He had progressive lower leg edema and shortness of breath and was found to have evidence of a restrictive pericarditis problem after his surgery. He was subsequently placed on diuretics and treated conservatively with significant improvement. He denies any abdominal pain, nausea or vomiting. He was recently seen by urology services and found that he had heme positive stool and this was detected on January 7th for the first time.

PAST MEDICAL HISTORY: He has history of aortic valve replacement, diabetes mellitus. He has history of hypertension, COPD, obstructive sleep apnea, hypothyroidism. He has history of paroxysmal atrial fibrillation. Peripheral neuropathy.

PAST SURGICAL HISTORY: He has had his aortic valve replaced, a cholecystectomy, circumcision, carpal tunnel release.

MEDICATIONS: Include Synthroid 0.15 qd, K-Dur 10 mg qd, Lasix 40 mg b.i.d., Coumadin 70 mg qd, Paxil 20 mg qd, Combivent inhaler, Rythmol 150 b.i.d. He is on Glucotrol XL 1 qd, Prevacid 15 mg qd. He has also been on Celebrex 100 mg b.i.d., Zoroxin 5 mg qd and he uses his bi-pap machine at home.

SOCIAL HISTORY: He is a retired coal miner. Currently is married, lives at home with his wife. Has no alcohol history but a long history of tobacco but quit a number of years ago, actually with his obstructive apnea.

FAMILY HISTORY: He has known diabetes in his mother. His father died with a stroke. No history of premature coronary disease.

REVIEW OF SYSTEMS: Shows that he has had some recent prostatism symptoms with some difficulty in voiding his stream and some nocturia. He has had some increasing peripheral edema. He has not had any chest pain, PND or orthopnea. He has marked dyspnea on exertion which is not unchanged for him. He has occasional palpitations.

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
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HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PHYSICAL EXAM: His blood pressure is 98/60 supine which dropped to 82/50 with a pulse of 76 to 80. He is somewhat pale. Pupils are equal and reactive. Sclera and conjunctiva are unremarkable with no scleral icterus. He has good carotid upstrokes without audible bruits. Thyroid is not palpable. Trachea is midline, no adenopathy. His lungs show some minimal rales at his bases. Cardiac shows a prosthetic valve click with a Grade I-II systolic murmur. NO diastolic murmur audible. His abdomen is obese. He has no tenderness or palpable organomegaly. Prostate is 3+. He has light heme positive stool. His extremities show 2+ pitting edema with some chronic stasis changes in his distal extremities. He has no palpable distal pulses. He has significant decrease in sensory findings on his distal extremity and absent ankle reflexes. No other focal motor change at this time. Patient is ambulatory albeit he is somewhat weak. There is no focal motor change and he is capable of ambulating at this time.

LABORATORY: Shows a hemoglobin of 9.5, BUN 48 with creatinine of 22. His electrolytes are abnormal with sodium of 130 and a potassium of 2.1.

IMPRESSION:

1. GI bleed.
2. Anemia secondary to #1.
3. Prosthetic valve on chronic anticoagulation therapy.
4. Renal insufficiency.
5. Hypokalemia.
6. History of restrictive pericardial disease.
7. Chronic obstructive lung disease.
8. Obstructive sleep apnea.

PLAN: He is admitted to Progressive Care Unit. Will undergo fluid resuscitation with potassium supplementation. His Coumadin will be placed on hold. Once his INR drops to subtherapeutic he will be started on Heparin. He will ultimately undergo GI evaluation. Serial hemoglobins will be monitored with transfusions if necessary. Routine labs, chest x-ray and EKG are obtained at this time.

Lynn Smith, M.D.

D: 01/14/00 1631
T: 01/14/00 1933
WKG
PMT, Inc. Job #: 7357

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GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/14/00

DISCHARGE DATE: 01/24/00

ATTENDING PHYSICIAN: Dr. Lynn Smith

DISCHARGE DIAGNOSES:

1. GI bleed, etiology not clear.
2. Valvular heart disease, status post aortic valve replacement.
3. Pernicious anemia.
4. Pulmonary hypertension.
5. Sleep apnea.
6. Mild renal insufficiency.
7. Restrictive pericardial disease, postoperative.
8. COPD.
9. Hypokalemia.
10. Hypothyroidism.
11. Noninsulin dependent diabetes mellitus.

DISCHARGE MEDICATIONS: 1500 cc fluid restriction, Synthroid, .15 per day, Paxil, 20 mgs qhs, Rythmol, 150 bid, Ferrous Sulfate, one po tid, KCL, 10 mEq tid, Lasix, 40 mgs bid, Aldactone, 50 mgs tid, Coumadin, 7.5 per day, Silvadene to leg qd, Neurontin, 400 mgs bid, Glucotrol-XL, one per day, 5 mgs, Pravacid, 15 mgs a day.

DISPOSITION: The patient was discharged home, will followup on Thursday, on 1/27/00 for re-evaluation.

SUMMARY: This is a 63 year old with a history of hypertension, aortic valve replacement due to bicuspid aortic valve and chronic anticoagulation therapy. Mr. Fitzwater began having episodes of weakness, had one syncopal episode on Monday when he was walking through the kitchen and suddenly found himself on the floor. He had been having progressive weakness over the last several weeks. He had noticed that every time he got up he would start to stagger. He had known aortic valve replacement in December, 1998 with a St. Jude's valve. He had progressive lower leg edema and had restrictive pericarditis after his surgery. He was subsequently placed on diuresis and conservatively treated with significant improvement. He had no other major complaints such as chest pain, shortness of breath, abdominal pain or nausea and vomiting.

PHYSICAL EXAM showed a blood pressure of 98/60 which dropped to 81/50 with a pulse of 76 to 80. Patient was pale. HEENT was unremarkable. He had minimal rales at the base. He had his prosthetic valve click and a Grade I to II systolic murmur, no diastolic component. Prostate was 3+. Stool was lightly heme positive. Extremities showed 2+ pitting edema with chronic stasis changes and a weeping area on the right lower leg. His hemoglobin was 9.5 with a BUN of 48 and a creatinine of 2.2. His electrolytes were abnormal with a sodium of 130 and potassium of 2.1.

Patient was initially placed in the progressive care unit, was given fluid

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 01/14/00

DISCHARGE DATE: 01/24/00

ATTENDING PHYSICIAN: Dr. Lynn Smith

resuscitation with potassium supplementation. His Coumadin was placed on hold. His INR went to drop down below therapeutic level at 2.5. He was started on IV Heparin and maintained on that at this time. He was seen in consultation by GI Services. Patient had some persistent left rib pain which was due to a fall. X-rays failed to reveal any significant fractures. His hemoglobin remained relatively stable at first, staying in about the 8-1/2 to 9 range. He still had the weeping peripheral edema. Patient was subsequently started back on some of his mild diuretic agents and did receive transfusion while in the hospital because of his anemia. He was seen by Gastroenterology Services and underwent both, an EGD and a colonoscopy. He did have some mild gastritis and multiple polyps that were removed but no other evidence of focal bleeding. The possibility of a small bowel source had to be considered.

The patient continued to improve. We were able to gradually get him back on his medications and diurese him with his blood pressure remaining stable as did his H&H. His creatinine stabilized. He was started back on Coumadin with an INR that subsequently came up to 2.5 at the time of his discharge. We felt that we would keep him on the lower end of anticoagulation. His potassium was 3.5 with creatinine of 1.6. He overall felt very well. With this we were able to discharge him home, to have very close monitoring on an outpatient basis and possible need for small bowel enteroscopy if he continues to have heme positive stools or persistent anemia.

Lynn Smith, M.D.

D: 02/05/00 0935

T: 02/05/00 1109

VMN

PMT, Inc. Job #: 1411

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

OPERATIVE REPORT

NAME: FITZWATER, JACKIE L
ROOM #: D.309

DOB: 04/25/36

UNIT #: D000038770

DATE OF OPERATION: 7/17/01

PREOPERATIVE DIAGNOSIS: Anemia

POSTOPERATIVE DIAGNOSIS: Gastroesophageal reflux disease. Gastric ulcer.
Hemorrhoids. Poor prep.

OPERATION PERFORMED: Esophagogastroduodenoscopy without biopsy. Colonoscopy.

SURGEON: Ray L. Jones, D.O.

ANESTHESIA: Versed 2 mg., Demerol 50 mg.
ESTIMATED BLOOD LOSS: Minimal

INDICATIONS: This is a 65 year old male who presents to the hospital with a history of anemia. The patient is on coumadin. The patient is here for evaluation of posterior pharyngeal region. The patient was given intravenous Versed and Demerol, the posterior pharyngeal region was intubated, the esophagus was found to be unremarkable. There was minimal reflux changes of the distal portion. The gastric mucosal pattern showed evidence of erythematous changes of the antrum with superficial ulceration within the antrum. There was no evidence of any mass, no other stricture or stenosis within the stomach. The pylorus was symmetrical. The duodenum was normal. The patient did not undergo biopsies because of his history of coumadin use.

The patient was then positioned for colonoscopy. Rectal examination was unremarkable. Prostate was normal. There were some hemorrhoids present. The colonoscope was inserted into the colon to about 70 cm. but I was unable to pass it past this point secondary to too much stool. The patient will be prepped for barium enema examination. The patient tolerated the procedure well and was transferred to the recovery room in stable condition.

Ray Jones, D.O.

D: 10/09/01 1011

T: 10/09/01 1417

JNM

cc: Dr. Lynn Smith

PMT, Inc. Job #: 4299

RECEIVED OCT 12 2001

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

4/27/00 252# 110/70 - P-76

Hosp F/U

B12 shot given per LNS - SA

Jackie Fitzwater
Post hospital follow-up.

1-27-2000

Lynn N. Smith, M.D.

S: Jackie is doing well, he was hospitalized with an episode of GI bleed, etiology still undetermined. They took out a number of polyps. His Hgb. Was 10 when he left. He has his known restrictive pericardial disease. Since going home he has done fairly well. His weight has stayed down. He has had no swelling in his legs other than his baseline.

O: On exam today lung fields are clear. Valve click is unchanged. He has about 1-2+ edema which is unchanged at this time.

A: IMPRESSION:

1. GI bleed, questionable etiology.
2. Status post aortic valve replacement with a restrictive pericardial disease.
3. Cor pulmonale.

P: His labs show a Hgb. Still of 9.9. His electrolytes are unremarkable. Creatinine is stable at 2.2 and his INR is 3.5. We have cut him down to 6 mg on his Coumadin a day, continue with his other medications and we will bring him back for follow-up in two weeks. T: 2-3-2000/crw

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

X-Ray No. 2958Date 4/13/98Age 61 y/oReferring Physician L. SmithExamination Desired Gastric emptying3.2 mCi Tc99m Sulfur Colloid

Fitzwater, Jack

Clinical Information Reflux, dysphagia, early satiety

Radiology Report:

NUCLEAR GASTRIC EMPTYING STUDY:

This study demonstrates a T1/2 of 60 minutes, which is in the range of normal. There is no evidence for abnormal lag time, and the emptying is relatively linear.

Impression:

Normal gastric emptying study. Occasionally a metoclopramide stimulation study could be of value for comparison. Clinical correlation advised.

Signed: David C. Maki, DO

RECEIVED DEC 16 1997

ESOPHAGOGASTRODUODENOSCOPY REPORT

Greenbrier Valley Medical Center

DATE: December 3, 1997

ENDOSCOPIST: Diego Gomez M.D.

REFERRING PHYSICIAN: Lynn Smith MD

PATIENT NAME: Jackie L. Fitzwater

HOSPITAL NO: 038770

HISTORY/INDICATIONS:

This upper endoscopy was performed for evaluation of abnormal upper gastrointestinal series, abdominal pain and early satiety.

INSTRUMENT: GIF-130**MEDICATIONS:** Demerol (meperidine) 100 mg IV
Versed (midazolam) 4 mg IV**BIOPSIES:** yes**BRUSHINGS:** no**PHOTOGRAPHS:** yes**PROCEDURE:**

A history and physical examination were performed. The procedure, indications, potential complications (bleeding, perforation, infection, adverse medication reaction), and alternatives available were explained to the patient who appeared to understand and indicated this. Opportunity for questions was provided and informed consent obtained. The endoscope was passed through the incisoral orifice into the oral cavity and under direct visualization the esophagus was intubated. The endoscope was passed down the esophagus, through the stomach and into the duodenum. A careful inspection was made as the endoscope was withdrawn. The patient tolerated the procedure well and there were no complications.

FINDINGS:**ESOPHAGUS:**

- Examination of the distal esophagus revealed a small hiatal hernia. (Image 1)
- Other than the findings noted above, there were no other esophageal abnormalities noted.

STOMACH:

- Mucosal abnormalities were noted in the antrum and prepyloric region and included streaks of erythema and diffuse edema, the presence of erosions. (Image 2) Biopsies were obtained from the antrum and prepyloric region.
- Other than the findings noted above, there were no other gastric abnormalities noted.
- Photodocumentation was obtained. (Image 4)

DUODENUM:

- The endoscope was passed into the second portion of the duodenum. The duodenum was normal and there was no evidence of duodenitis, duodenal ulcers, nodules, diverticula, intrinsic, or extrinsic masses, polyps, arteriovenous malformations (AVM's), in the duodenum, duodenal bulb, or pylorus.

IMPRESSION:

- Hiatal hernia
- Nonspecific gastritis (biopsied)
- The most likely diagnosis for the gastric inflammation is

Jackie L. Fitzwater
038770Endoscopy Unit
Form No 111-589/Rev 7/89Date: 12/03/97
Time: 3:40
App: 000004

ESOPHAGOGASTRODUODENOSCOPY REPORT

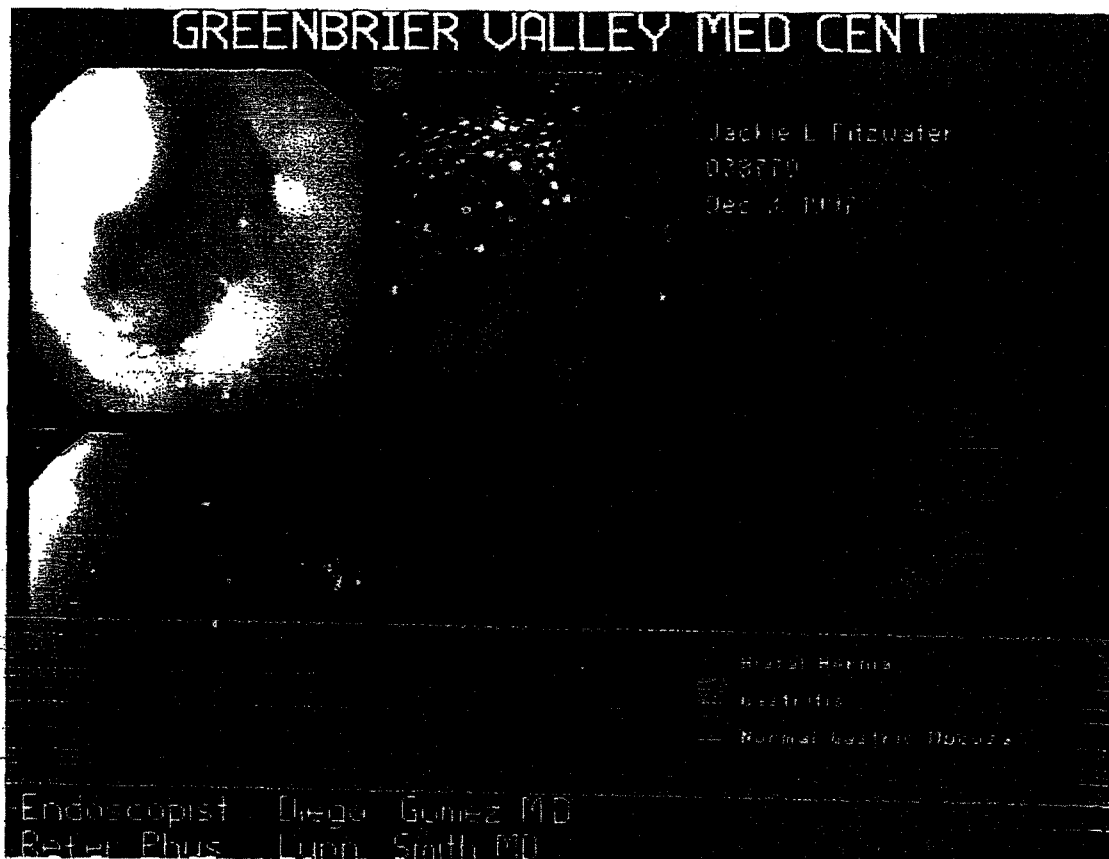
Greenbrier Valley Medical Center

Helicobacter pylori associated gastritis.

RECOMMENDATIONS:

- Follow up the biopsy results
- Prilosec (omeprazole) 20 mg po B.I.D.
- Follow up with GI clinic within 1 month

Diego Gomez M.D.



Jackie L. Fitzwater
038770

Endoscopy Unit
Form No 111-589/Rev 7/89

Date: 12/03/97
Time: 09:40
341
App.000605

Columbia Greenbrier Valley MC
Box 497
Ronceverte, WV 24970

RECEIVED OCT 3 1997
NAME: FITZWATER, JACKIE L
PHYS: Smith, Lynn
DOB: 04/25/36 AGE: 61 SEX: M
ACCT: D00098020749 LOCATION: DRD
EXAM DATE: 10/02/97 STATUS: OUT
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901
(304) 645-3207

EXAMS: 000020942 GI UPPER SERIES

UPPER GI:

CLINICAL HISTORY: Swallowing problem. (38246-jf)

The swallowing mechanism was intact. Tertiary esophageal wave formation was identified. There is a small sliding hiatal hernia with some reflux. The gastric mucosa is well coated. The rugal folds are slightly prominent in its superior portion. Within the antrum there were two 1 cm sessile polypoid filling defects identified along the greater curvature. These may represent some hyperplastic polyps. Is there a history of alcohol intake? Perhaps endoscopy would be warranted.

The duodenal bulb and proximal small bowel mucosa were normal.


IMPRESSION: TERTIARY ESOPHAGEAL WAVE FORMATION. POSSIBLE TWO SESSILE GASTRIC POLYPS.

If this report has been electronically signed the radiologist whose name appears on this report has reviewed the films and has edited the report.

** REPORT SIGNATURE ON FILE 10/02/97 **
REPORTED AND SIGNED BY: Heather Rose, M.D.

CC: Lynn Smith, M.D.

TECHNOLOGIST: Susan B Poague RT(R) (M)
TRANSCRIBED DATE/TIME: 10/02/97 (1207)
TRANSCRIPTIONIST: DMRMEK
PRINTED DATE/TIME: 10/02/97 (1348) BATCH NO: 589



Jackie Fitzwater

04-24-96

WT 258

BP 115/80

P 12

u follow up

4-26-96 pt's wife advised needs repeat CFTS in 2 wks.

pc

Jackie Fitzwater

4-24-96

Dr. L. Smith

S: Jackie is having a lot of GI problems with his Glucophage, nausea, bloating, diarrhea, he just doesn't feel well since he has been on it even though it has helped his sugar control and has obviously helped his neuropathy symptoms.

O: His other problems is with his hands and feet. He has evidence of what appears to be diffuse tinea involvement, nails, hands, scaley, dryness.

A: Impression: 1. Diabetes type II.
2. Peripheral neuropathy.
3. Tinea hands, and tinea pedis.

P: We are going to put him on Diflucan 100 a day, DC the Glucophage and put him back on Glucotrol 5 mg a day. His routine lab work and Hgb. A1-C is drawn today and he is to follow up in two weeks. I have only given him enough tablets of the Diflucan for 14 days, 100 mg. LNS/crw

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 64 SEX: M
ACCT: D00098179648 LOC: D.331 A
EXAM DATE: 01/06/2001 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000213291 CHEST AP/PA & 1 LATERAL

CHEST, TWO VIEWS.

CLINICAL HISTORY: PLEURAL EFFUSION.

There is a small to moderate pleural effusion on the right which has not significantly changed since the previous day. No pneumothorax is seen. There is likely is subsegmental atelectasis at the right base. There has been a previous sternotomy. Underlying COPD is seen.
IMPRESSION: EFFUSIONS.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT 4515.

** Electronically Signed by Heather Rose M.D. on 01/06/2001 at 1334 **
Reported and Signed by: Heather Rose M.D.

CC: Lynn Smith, M.D.

Dictated Date/Time: 01/06/2001 (1246)

Technologist: Ruth E Craft RT(R) (M)

Transcribed Date/Time: 01/06/2001 (1326)

Transcriptionist: PMTJNM

Printed Date/Time: 01/06/2001 (1339) BATCH NO: 4879

PAGE 1

Lynn Smith, M.D.

RECEIVED JAN 09 2001

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Stout, E. Jonathan
DOB: 04/25/1936 AGE: 64 SEX: M
ACCT: D00098159828 LOC: DER
EXAM DATE: 08/17/2000 STATUS: REG ER
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

RECEIVED AUG 21 2000

EXAMS: 000191527 CHEST AP/PA & 1 LATERAL

CHEST, TWO VIEWS

CLINICAL HISTORY: SHORTNESS OF BREATH

There has been a previous sternotomy. Mild to moderate cardiomegaly is seen. There is underlying interstitial lung disease. No edema or consolidation is seen.

IMPRESSION: CHRONIC CHANGE.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

PMT4070

Electronically Signed by Heather Rose M.D. on 08/17/2000 at 1639
REPORTED AND SIGNED BY: Heather Rose M.D.

S

CC: Lynn Smith, M.D.; E. Jonathan Stout, D.O.

Dictated Date/Time: 08/17/2000 (1420)

Technologist: Joe R Sparks RT(R)

Transcribed Date/Time: 08/17/2000 (1511)

Transcriptionist: PMTKAC

Printed Date/Time: 08/17/2000 (1641) BATCH NO: 4239

PAGE 1

Lynn Smith, M.D.

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Burnette, Gregory K
DOB: 04/25/1936 AGE: 62 SEX: M
ACCT: D00098079452 LOC: DER
EXAM DATE: 01/15/1999 STATUS: DEP ER
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000087696 PORTABLE CHEST AP/PA ONLY

PORTABLE CHEST:

CLINICAL HISTORY: HEART PROBLEMS

There is moderate to severe cardiomegaly. A previous sternotomy has been performed. There is hyperinflation with an increase in the markings seen in keeping with COPD. There is no edema or consolidation.

IMPRESSION: CARDIOMEGALY.
VERBAL GIVEN.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** REPORT SIGNATURE ON FILE 01/18/1999 **
REPORTED AND SIGNED BY: Heather Rose, M.D.



CC: Gregory K Burnette, D.O.; Lynn Smith, M.D.

Dictated Date/Time: 01/15/1999 (1030)

Technologist: Carol M Creasman RT(R)

Transcribed Date/Time: 01/16/1999 (1328)

Transcriptionist: DMRLMC

Printed Date/Time: 01/18/1999 (1034) BATCH NO: 2089

PAGE 1

Lynn Smith, M.D.

RECEIVED MAR 12 1999

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 62 SEX: M
ACCT: D00098086916 LOC: DRD
EXAM DATE: 03/11/1999 STATUS: REG CLI
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000097714 CHEST AP/PA & 1 LATERAL

CHEST

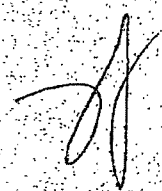
CLINICAL HISTORY: HYPOXIA

There is hyperinflation with an increase in markings seen in keeping with COPD. There has been a previous CABG. Moderate cardiomegaly is seen.

IMPRESSION: CHRONIC CHANGE
VERBAL GIVEN

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** REPORT SIGNATURE ON FILE 03/11/1999 **
REPORTED AND SIGNED BY: Heather Rose, M.D.



CC: Lynn Smith, M.D.

Dictated Date/Time: 03/11/1999 (1015)

Technologist: Emmy L Broce RT(R)

Transcribed Date/Time: 03/11/1999 (1216)

Transcriptionist: DMRKAC

Printed Date/Time: 03/11/1999 (1245) BATCH NO: 2287

PAGE 1

Lynn Smith, M.D.

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

RECEIVED SEP 03 1999

X-Ray Requisition & Report

Fitzwater, Jack

X-Ray No. 2958
Date 8-25-99
Age 4-25-36
Referring Physician Durham
Examination Desired EXR

Clinical Information SOB

Radiology Report:

JACK FITZWATER

CHEST, TWO VIEWS:

Two views of the chest are compared to study of May 1998.

The present examination demonstrates large right effusion. Cardiomegaly with venous congestion. Pleural thickening and/or tracking effusion on the lateral right chest wall.

Of note - there is improved appearance in the 8/31 exam when compared to the 8/25 exam. Continue following to resolution.

T: 9-1-99
DCM/crw

Signed by David C. Maki, D.O.

Chart

W

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

Fitzwater, Jackie

X-Ray No. 2958

Date 9-10-99

Age 4-25-36

Referring Physician L Smith

Examination Desired CXR w/

Ⓡ Decubitus

Clinical Information

Ⓡ Effusion

Radiology Report

JACKIE FITZWATER

CHEST WITH DECUBITUS VIEWS:

The chest continues to demonstrate a right pleural effusion with venous congestion and interstitial edema, cardiomegaly and post thoracotomy changes are seen.

The decubitus views demonstrate a layering right effusion with goes along the lateral hemithorax.

IMPRESSION: THERE IS A RIGHT PLEURAL EFFUSION WHICH LAYERS ON DECUBITUS MANEUVER. CARDIOMEGALY. VENOUS CONGESTION AND INTERSTITIAL EDEMA.

T: 9-13-99

DCM/crw

Signed by David C. Maki, D.O.

Echo

allied 9/17/99 6P

9/16/99 Left mess lora

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

CA 7
fond
JAC

RECEIVED SEP 08 19

X-Ray Requisition & Report

Fitzwater

Jack

X-Ray No. 2958
Date 8/31/99
Age 42 5/36
Referring Physician L Smith
Examination Desired CXR

Clinical Information * Need to Do decub if effusion
Seen - Call results

Radiology Report:

JACK FITZWATER

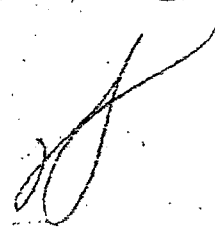
CHEST, TWO VIEWS:

Two views of the chest demonstrate a right pleural effusion. Cardiomegaly. Status post thoracotomy.

IMPRESSION: EFFUSION WITH CARDIOMEGALY. THERE MAY BE SOME MILD VENOUS CONGESTION AS WELL. CONSIDER SOME DEGREE OF UNDERLYING CONGESTIVE FAILURE.

T: 9-1-99
DCM/crw

Signed by David C. Maki, D.O.



Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Durham, Richard R
DOB: 04/25/1936 AGE: 63 SEX: M
ACCT: D00098115368 LOC: DOPS
EXAM DATE: 10/06/1999 STATUS: REG SDC
RADIOLOGY NO: 38246
UNIT NO: D000038770

Richard R Durham, M.D.
Rt 2, Box 171
Lewisburg, WV 24901

EXAMS: 000135253 PORTABLE CHEST AP/PA ONLY

CLINICAL HISTORY: POST THORACOCENTESIS

There is a tiny right pleural effusion. There is moderate cardiomegaly. There is mild accentuation of the lung markings. There is no pneumothorax. There has been previous sternal split.

IMPRESSION: CARDIOMEGALY. RIGHT PLEURAL EFFUSION.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** REPORT SIGNATURE ON FILE 10/07/1999 **
REPORTED AND SIGNED BY: Colin Rose M.D.

RECEIVED OCT 11 1999

CC: Richard R Durham, M.D.; Lynn Smith, M.D.

Dictated Date/Time: 10/06/1999 (1350)
Technologist: David L Weikle AS, RT(R)
Transcribed Date/Time: 10/07/1999 (1032)
Transcriptionist: DMRLMC
Printed Date/Time: 10/07/1999 (1226) BATCH NO: 2974

PAGE 1

Richard R Durham, M.D.

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Durham, Richard R
DOB: 04/25/1936 AGE: 63 SEX: M
ACCT: D00098115368 LOC: DOPS
EXAM DATE: 10/06/1999 STATUS: REG SDC
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000135253 PORTABLE CHEST AP/PA ONLY

CLINICAL HISTORY: POST THORACOCENTESIS

There is a tiny right pleural effusion. There is moderate cardiomegaly. There is mild accentuation of the lung markings. There is no pneumothorax. There has been previous sternal split.

IMPRESSION: CARDIOMEGALY. RIGHT PLEURAL EFFUSION.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

** REPORT SIGNATURE ON FILE 10/07/1999 **
REPORTED AND SIGNED BY: Colin Rose M.D.

CC: Richard R Durham, M.D.; Lynn Smith, M.D.

RECEIVED OCT 11 1999

DICTATED DATE/TIME: 10/06/1999 (1350)
TECHNOLOGIST: David L Weikle AS, RT(R)
TRANSCRIBED DATE/TIME: 10/07/1999 (1032)
TRANSCRIPTIONIST: DMRLMC

PRINTED DATE/TIME: 10/07/1999 (1229) BATCH NO: 2974

PAGE 1

Lynn Smith, M.D.

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 63 SEX: M
ACCT: D00098115976 LOC: D.PCU 3
EXAM DATE: 10/11/1999 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000136243 CHEST AP/PA & 1 LATERAL

CLINICAL HISTORY: SHORTNESS OF BREATH.

There has been a deterioration since 10/06/99. There is a moderate right pleural effusion with basilar subsegmental atelectasis. Moderate cardiomegaly is seen. There is underlying COPD. A previous sternotomy has been performed.

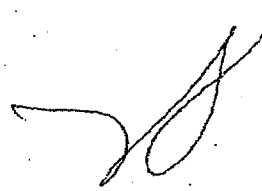
IMPRESSION: DETERIORATION SINCE 10/06/99.

VERBAL GIVEN.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

#8008

** REPORT SIGNATURE ON FILE 10/12/1999 **
REPORTED AND SIGNED BY: Heather Rose M.D.



RECEIVED OCT 14 1999

CC: Lynn Smith, M.D.

DICTATED DATE/TIME: 10/11/1999 (1601)
TECHNOLOGIST: Ron W Cruse RT(R)
TRANSCRIBED DATE/TIME: 10/12/1999 (0929)
TRANSCRIPTIONIST: DMRREG
PRINTED DATE/TIME: 10/12/1999 (1157) BATCH NO: 2988

PAGE 1

Lynn Smith, M.D.

Greenbrier Valley Medical Center
P.O. Box 497
Ronceverte, WV 24970

PHONE #: (304) 647-6075
FAX #: (304) 647-6525

NAME: FITZWATER, JACKIE L
ATTENDING DR: Smith, Lynn
DOB: 04/25/1936 AGE: 63 SEX: M
ACCT: D00098115976 LOC: D.309 B
EXAM DATE: 10/13/1999 STATUS: ADM IN
RADIOLOGY NO: 38246
UNIT NO: D000038770

Lynn Smith, M.D.
ROUTE 2 BOX 171
LEWISBURG, WV 24901

EXAMS: 000136382 US ABDOMEN

CLINICAL HISTORY: POSSIBLE ASCITES AND HEART FAILURE.

There are large lateral effusions visualized. No definite ascites is seen. The common bile duct was very difficult to clearly visualize in part due to the patient's shortness of breath. It may be slightly dilated either 6 or 8 mm. Perhaps a CT would be a better way to screen the size. The pancreas is difficult to visualize due to overlying bowel gas and a midline scar. There is no hydronephrosis. There has been a previous cholecystectomy.

IMPRESSION: PLEURAL EFFUSIONS. NO ASCITES. POSSIBLE DILATED COMMON BILE DUCT.

If this report has been electronically signed, the radiologist whose name appears on this report has reviewed the films and the report.

#8356

** REPORT SIGNATURE ON FILE 10/13/1999 **
REPORTED AND SIGNED BY: Heather Rose M.D.



CC: Lynn Smith, M.D.

Dictated Date/Time: 10/13/1999 (0800)

Technologist: Bethany L Allen

Transcribed Date/Time: 10/13/1999 (1212)

Transcriptionist: DMRREG

Printed Date/Time: 10/13/1999 (1315) BATCH NO: 2994

PAGE 1

Lynn Smith, M.D.

RECEIVED OCT 14 1999

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

Fi + 2 water

JACK

X-Ray No.

2958

Date

4 25 99

Age

10 6 99

Referring Physician

Dusham

Examination Desired

CXR

Clinical Information

COPD

Radiology Report:**JACK FITZWATER****CHEST, TWO VIEWS:**

Larger right pleural effusion when compared to 9/10 with volume loss and atelectasis. Gross cardiomegaly. Status post thoracotomy. Increased interstitial and venous markings.

IMPRESSION:

1. FINDINGS CONSISTENT WITH CONGESTIVE FAILURE WITH UNDERLYING EMPHYSEMATOUS CHANGE.
2. LARGE RIGHT PLEURAL EFFUSION WITH VOLUME LOSS. EFFUSION HAS BEEN SEEN SIZE 3/99.

PERHAPS THORACENTESIS AND/OR CT WOULD BE OF VALUE TO FURTHER ASSESS.

T: 10-14-99
DCM/crw

Signed by David C. Maki, D.O.

RECEIVED OCT 19 1999

RECEIVED MAY 11 1998

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

*Jack
Fitzwater*

X-Ray No. 2958Date 5-7-98Age 4-25-36Referring Physician J SmithExamination Desired CXRClinical Information Cover

Radiology Report:

CHEST 2 VIEWS:

There is no acute infiltrate. There are mild increased interstitial and bronchovascular markings. Mild spondylosis of the thoracic spine seen. Heart size and pulmonary vasculature appear normal. There may be some focal scarring in the right lower lung at the costophrenic angle. Pleural thickening is present-particularly on the right. No effusion present. perhaps recheck in 1-2 weeks would be of value.

Signed: David C Maki D.O.

[Signature]

VALLEY MEDICAL IMAGING CENTER

Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

X-Ray Requisition & Report

Fitzwater, Jack

X-Ray No. 2958

Date 1-15-98

Age 4-25-36 (61 y)

Referring Physician L. Smith

Examination Desired CXR²

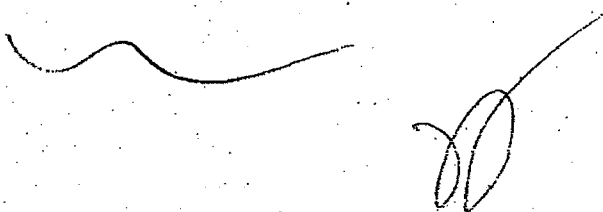
Clinical Information S.O.B., Smoker 25y R/O COPD

Radiology Report:

CHEST two views:

There is no evidence for acute infiltrate. Bilateral pleural thickening present.
Underlying pulmonary fibrosis. Mild hyperinflation.

Signed: David C Maki D.O.



Patient Name

Jackie Fitzwater

Age

69

Date

10-4-05

Lynn N. Smith, M.D.

Doris A. Ragsdale, M.D.

John W. Galbreath, M.D.

Chief Complaint

Pertinent Past Medical History

Past Surgical History

Medications

JACKIE FITZWATER

10/4/2005

S: Mr. Fitzwater is in today and just doesn't feel well. His sugars have remained high at home. He has not had any evidence of any overt infectious problems. His weight has been relatively stable. He is still quite short of breath at times. Still using his oxygen.

Review of Systems: No chest pains or palpitations. He has had no nausea, vomiting or diarrhea. He has no dysuria. He is still smoking unfortunately according to the daughter although it is quite restricted and she has admitted that she is not willing to go out and buy any more cigarettes for him.

FAMILY HISTORY

PHYSICAL EXAM:

Ht _____ Wt 25 1/2 BP 116/58 Pulse 92 Temp _____ Resp _____

EXAM

Normal

Abnormal

Comment

General

LAB

A1C

ALT/LIVER

Hemocult X3Positive X3FBS-447mg/dl

EXAMINATION: His lungs still show some decreased breath sounds at the right base consistent with an effusion. Cardiac: He has atrial fib with no new murmurs or gallops. His peripheral edema is 1+. His abdomen is non-tender. His gait is actually better at this time than it has been.

IMPRESSION:

1. History of CHF with probable right pleural effusion.
2. Atrial fib, chronic.
3. COPD.
4. Diabetes mellitus, poorly controlled.

PLAN: We are going to get his labs drawn today including basic metabolic panel, his pro time and his CBC. It should be noted this gentleman has had Hem-positive stools persistent on his last workup. We will increase his Glyburide to 5 mg 3 times a day. I will talk to his daughter within the next couple of days so we can determine next course of action after we have had a change to review his lab work and his chest x-ray.

Lynn N Smith, MD/NM/aw

PLAN:

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L.

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 08/30/02

DISCHARGE DATE: 09/14/02

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

DISCHARGE DIAGNOSIS:

1. Tachy brady syndrome with recurrent atrial tachy arrhythmias.
2. Chronic obstructive lung disease.
3. Congestive heart failure with predominantly cor pulmonale.
4. Pneumoconiosis.
5. Hypothyroidism.
6. Status post prosthetic valve.
7. Anemia.

PROCEDURE: Insertion of transvenous dual chamber pacing device with atrial fibrillation suppression.

DISCHARGE MEDICATIONS: Coumadin 10 mg this evening, Demadex 100 p.o. b.i.d., iron tablets one p.o. b.i.d., Synthroid 0.2 mg per day, Glucotrol one per day, Plomax 0.4 mg per day, Prilosec 20 mg per day, Neurontin 300 mg b.i.d., Reglan before meals prn, Proscar 5 mg per day. The patient is using a combination of Serevent during the day, but uses Albuterol nebulizers on a regular basis.

DISPOSITION: The patient is discharged home. Followup appointment in one week.

SUMMARY: This is a 66 year old with a history of chronic cor pulmonale with restrictive pericarditis with recurrent right-sided heart failure. He presented with increasing shortness of breath and weight gain. He'd had about a 20 lb weight gain over about the last 10 days. He'd had frank orthopnea and dyspnea on exertion and increasing peripheral edema.

PHYSICAL EXAM: On presentation, his weight was up 20 lbs. Blood pressure was 106/64, heart rate was 114 to 130 which was irregularly irregular. HEENT showed a positive jugular reflux. He had a known valve click with a systolic murmur. No audible S3 gallops. He had 2 to 3+ pitting edema.

LABORATORY: On presentation, protime was therapeutic at 3.25. Hemoglobin was 9.1 with normal indices. BUN was normal with a creatinine of 1.5. Liver functions were also normal. The patient was found to be in atrial fibrillation with episodes of atrial flutter.

HOSPITAL COURSE: Initially, he was placed in the Progressive Care Unit where the patient was subsequently digitalized to try to obtain control of his heart rate. He was also put on low dose Beta blockers. He has a history of symptomatic brady arrhythmias in the past, and because of this, it was felt that he had evidence of tachy brady syndrome and would be in need of a permanent pacemaker. A consult was

***** DISCHARGE SUMMARY *****

GREENBRIER VALLEY MEDICAL CENTER
PO BOX 497
RONCEVERTE, WV 24970
(304) 647-4411

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

UNIT #: D000038770

ADMISSION DATE: 08/30/02

DISCHARGE DATE: 09/14/02

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

placed and the patient subsequently had a permanent pacemaker placed at this time. We were able to adequately control heart rate at that time. Low dose Beta blockers initially and subsequently digitalization. The patient was initially placed Heparin and was controlled that way so that the pacemaker could be planted. After this was done, he was converted back over to his Coumadin and level was basically brought back up to the therapeutic range at the time of his discharge. At this time, he is much improved. His heart rate is under control. His failure was cleared and he feels better. He still has the mild anemia. Stool hemocults at this time are negative and that will be monitored closely on an outpatient basis. He has been started on iron therapy at this time and will followup in the office on an outpatient basis.

Lynn N. Smith, M.D.

D: 10/09/02 1640

T: 10/10/02 0943

VGC

PMT, INC. #6668

***** DISCHARGE SUMMARY *****

Dictating Physician's copy

Patient Name: Jackie Fitzwater Age 65 Date 3/20/02Lynn N. Smith, M.D.
Doris A. Ragsdale, M.D.Chief complaint Bad Cold Blood work

Pertinent Past Medical History

Past Surgical History

Medications

GENERALWt Change _____
Fever _____
Chills _____
Sweats _____
HA _____
Weakness _____
Appetite _____**GENTOURINARY**Polyuria _____
Dysuria _____
Nocturia _____
Vag discharge _____
LMP _____**CARDIOVASCULAR**Chest Pain _____
SOB _____
Palpitation _____
Edema _____
HTN _____
PND _____
Orthopnea _____**MUSCULOSKELATAL**Arthralgia _____
Myalgia _____
Stiffness _____
Joint swelling _____
Injury _____**RESPIRATORY**Sputum _____
DOE _____
Pleurisy _____
Cough _____
Hay Fever _____
Asthma _____
Hemoptysis _____**SOCIAL HISTORY**Smoking _____
ETOH _____
Diet _____
Exercise _____**GASTROINTESTINAL**Abd Pain _____
Diarrhea _____
Constipation _____
Melena _____
Pain _____**ENT**Sore Throat _____
Ear Ache _____
Visual Chgs _____
Vertigo _____
Rhinitis _____**FAMILY HISTORY****PHYSICAL EXAM:**Ht _____ Wt 265 BP 110/72 Pulse 70 Temp _____ Resp _____

Jackie L. Fitzwater

03-20-02

Lynn N. Smith, M.D.

S: Jackie comes in today. He developed a URI over the weekend. He has had a cough with some mild yellow sputum production, little bit of increasing shortness of breath. Part of the reason that he is doing quite well is that he has quit smoking and he has been exercising and his weight has been stable. He has very little peripheral edema. He has not used any of his extra diuretics during this time frame.

ROS shows that he has not had any frank PND. No high fevers, chills, sweats or pleuritic pain. No nausea or vomiting or any recent viral complaints or general malaise.

EXAMINATION: He has some scattered rhonchi. A congested cough with some minimal sputum production. No evidence of any consolidation or pleural rubs. He has his valve click, consistent with his prosthetic valve. He still has his trace to 1+ pitting edema which is stable for him. No evidence of hypoxia and his O2 sats are 95%.

IMPRESSION:

1. URI
2. COPD.
3. Diabetes mellitus.
4. History of prosthetic valve.
5. Known restrictive pericarditis.

PLAN: 1. We will put him on Cefzil 250mg bid. He is going to continue with his nebulizer therapy. I have asked him to watch closely for any worsening symptoms such as fevers, sweats or chills at which time a chest x-ray might be necessary. 2. He is having his protine and his potassium level checked today.

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

3/28/0126794/5092Chest
congestion

Jackie L. Fitzwater

03/28/01

Lynn N. Smith, M.D.

S: Jackie comes in. For the last 2-3 days he has been coughing. He has had increasing shortness of breath and wheezing and a brownish sputum production. No significant fevers or chills or night sweats. He has had no change in his peripheral edema.

EXAMINATION: He is coughing frequently with a productive mucoid mucous. He has bilateral rhonchi with expiratory wheezing. He is not in any respiratory distress. Cardiac exam is unchanged. He

Jackie Fitzwater

Page 2

03/28/01

Lynn N. Smith, M.D.

still has about 1+ edema which is improved for him. BP is down around 100/60.

IMPRESSION:

1. Bronchitis with exacerbation of COPD
2. Known restrictive heart disease
3. Hypothyroidism

PLAN: 1. We are going to put him on Levaquin 500mg qd. 2. We will give him 60mg of Sodium Medrol and a Medrol DosePak to taper at this time. 3. We will bring him back in for f/u in approximately 10 days.

L. Smith, M.D./ssd/D: 3-28-01/T: 4-3-01

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

*7/24/00**267**104/58**96**SW B
1/4 chest cong.**B-12 medication now kept*

Jack Fitzwater

7/24/00

Lynn Smith, M.D.

S: Mr. Fitzwater is in today primarily with some complaints of having been itching some; has had a little bit of congestion and cough. His peripheral edema seems to have gotten better with the pneumatic hose that he is using now. He uses them during the nighttime - gets up, and his swelling is quite a bit better. He does complain of dry mouth.

O: LUNGS: Lung fields are clear; some scattered rhonchi, but they really sound pretty good with no major wheezing. He does have some bilateral parotid enlargement. He is on **Spironolactone** and has a history of having lumps as a child; no other adenopathy.

SKIN: There is no rash identified; no evidence of jaundice.

EXTREMITIES: Peripheral edema is essentially unchanged.

GENERAL: His weight is up a couple of pounds.

IMPRESSION:

1. Severe COPD - restrictive cardiac disease and cor pulmonale
2. Pruritus - questionable etiology
3. Parotid enlargement

PLAN: 1. We are going to get his complex metabolic panel, a sed rate, and an anti-SSA and SSD antibodies. 2. He is going to use some **Sarna** lotion for his arms for his itching. 3. We will follow-up as soon as we have these results.

L. N. Smith, M.D./mek/D: 7-24-00/T: 8-08-00

7/31-00 NO Show for Appt.

FOR	<i>Nurse</i>	DATE	<i>7/25</i>	TIME	<i>11:02</i>	AM P.M.
M	<i>Jackie Fitzwater</i>					
OF						
PHONE	<input type="checkbox"/> FAX <input type="checkbox"/> MOBILE	<i>438-6633</i>				
MESSAGE		<i>Blat work Results</i>				
		<i>Should go back on Celebrex Sp...</i>				
SIGNED		<i>JLS</i>				

*4-1-00**Celebrex 100mg**#30 - 9d 3RF**called to**Winnwil*

363

App.000627

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: _____

DATE _____ WT _____ BP _____ PULSE _____ CC: _____

WHILE YOU WERE AWAY

FOR	Nurse	DATE	5/8	TIME	8:50 A.M.
M	Jack Fitzwater				
OF					
PHONE	<input type="checkbox"/> FAX	438-6633			
	<input type="checkbox"/> MOBILE	AREA CODE	NUMBER	EXTENSION	
MESSAGE					
Needs to know if he is to					
Continue taking the fluid pill					
5/8 left msg. re pt. Advised					
SIGNED	5/8/00 JNS FORM 4002				

5-15-00. Wt. 271 B/P 115/70 P 76 CC SOB

JACK FITZWATER

5/15/00

Lynn N. Smith, M.D.

S: For the last week or ten days Jack has been having an increase in cough. He has had some increase in shortness of breath with dyspnea on exertion. He has had a lot of allergy symptoms with the roof of his mouth itching, nasal itching, sneezing, and his eyes are bothering him. He has been coughing up what he says is some brown type material periodically. He has been blowing it also out from his nose. When we put him on Cefzil several weeks ago he said that he felt great within 48 hours but it just didn't hold. His weight has gone up slightly and he is a little bit concerned that it could have been his heart. He has not had any chest pain. No fever, chills, or sweats. His appetite has been good. He has been taking his medicine on a regular basis, and his fluid medicine, but he has been using Combivent only 2-3 times per day. On exam today, resting, he is in no distress. His blood pressure is adequate. His lung fields show expiratory wheezing in the right lung with some forced expiratory wheezing. He has some scattered rhonchi. No significant rales. His chest x-ray within 10 days showed no evidence of effusion or failure at that time. He does have his peripheral edema, which is unchanged. His weight is up about 4 pounds.

IMPRESSION:

1. Allergic rhinitis with active bronchitis.
2. Exacerbation of bronchospastic lung disease, secondary to number one (1).
3. Poor pulmonality with known chronic and lung disease and valvular heart disease.

PLAN: We are going to have him on Prednisone 20 mg and taper over the next ten (10) days. Levaquin 500 mg a day for 10 days. He is going to continue with his other medicines at this time and will follow-up in nine days so that we can make sure that this is completely cleared.

GREENBRIER VALLEY MEDICAL CENTER
P.O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L

DOB: 04/25/36

ROOM #: D.309

UNIT #: D000038770

ADMISSION DATE: 07/06/06

ATTENDING PHYSICIAN: Dr. Lynn N. Smith

This 70 year old gentleman presents with increasing shortness of breath and peripheral edema. He has known severe cor pulmonale from a combination of pneumoconiosis, pulmonary hypertension and restrictive pericarditis. He has also had recurrent GI bleeds believed predominantly due to AV malformations in the small bowel although we have not been able to corroborate this because of inability to get the small bowel capsule endoscopy done. He has had this scheduled on two different occasions but both times he has been acutely ill and had to cancel. Because of increasing shortness of breath and weakness he was presented back to the hospital. He was found to have a significant drop in his hemoglobin down to 6.9. It had been 10.3 about 2 weeks ago. He also has an INR that shot up to 7 with marked increasing edema believed secondary to passive liver congestion. His last INR was 3.8 approximately two weeks ago and under good control. He has not had any chest pain. He has had minimal cough and sputum production. He has gotten progressively weaker, much more edematous and has presented to the hospital with these complaints.

PAST MEDICAL HISTORY: He has history of right-sided heart failure with cor pulmonale, pneumoconiosis, renal insufficiency, severe peripheral neuropathy, diabetes type 2 on oral agents, history of restrictive pericarditis. He is on chronic anticoagulation therapy due to a prosthetic aortic valve. He has had history of some GI bleed in the past both with erosive gastritis and believed most recently now with probable small bowel bleeds believed due to AVMs. He also has known history of hypertension, chronic ataxia with cerebellar dysfunction, hypothyroidism.

PAST SURGICAL HISTORY: He has had aortic valve replaced due to rheumatic heart disease, cholecystectomy, appendectomy, pacemaker due to tachy-brady syndrome and a pericardial _____ due to his restrictive pericarditis.

ALLERGIES: He has no known drug allergies.

CURRENT MEDICATIONS: Numerous and listed at this time on his admission.

FAMILY HISTORY: Both parents are deceased. Mother had diabetes. Father had heart failure. There is no history of any other malignancies or premature coronary disease.

SOCIAL HISTORY: He is a retired coal miner. He lives at home with his wife. He does have a history of smoking. Unfortunately he is still actively smoking several cigarettes a day, probably closer to a half a pack according to his daughter. No significant alcohol.

REVIEW OF SYSTEMS: Weight is up about ten pounds within the last week. No fever, chills or sweats. **HEENT:** He has no visual or hearing deficits or difficulty in

RECEIVED JUL 10 2006

GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

swallowing. Cardiac: No chest pains. Occasional palpitations. He has had some PND orthopnea with his recent shortness of breath. Pulmonary: Minimal cough, sputum. No discoloration, no hemoptysis. GI: He has had no nausea but he has noted some black melanotic type stool within the last three to four days. GU: He has known BPH without obstruction and just recently had a Foley catheter placed about a week ago because of urinary retention by his urologist. Musculoskeletal: He has known severe peripheral neuropathy due to both post inflammatory and diabetic neuropathy. No history of seizures. No history of focal motor abnormalities.

PHYSICAL EXAM: He is alert. He is oriented at this time. He is grossly edematous even with some periorbital puffiness. He has gross anasarca up to his waist. He has pale conjunctiva. There is no scleral icterus. He has no major JVD but he is sitting at 90 degrees. He has decreased breath sounds at his right base with a known loculated effusion. He has an irregular heart rate with a grade II murmur left lower sternal border and a valve click and no diastolic aortic murmur. His abdomen is obese. Bowel sounds are active with probable some mild ascites. He has 3-4+ pitting edema bilaterally. He has early skin break down with some weeping on the left leg as noted. Stool is melanotic and heme positive at this time. Neurologically he has decreased sensory in his legs consistent with his neuropathy. No focal motor abnormalities but we have not ambulated him at this time. He is diffusely weak with about 3/5 motor.

Hemoglobin is 6.9 with a normal white count and platelets. BUN is elevated at 72 with a creatinine of 1.9. Electrolytes are unremarkable. Chest x-ray shows a loculated effusion. His EKG shows atrial fib with a controlled rate. INR is elevated at 7.

IMPRESSION:

1. Anemia with GI bleed most likely small bowel.
2. Coagulopathy secondary to passive liver congestion.
3. Cor pulmonale with worsening right sided failure.
4. Restrictive pericarditis.
5. Pneumoconiosis.
6. Statuspost prosthetic valve.

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GREENBRIER VALLEY MEDICAL CENTER
P. O. BOX 497
RONCEVERTE, WV 24970

HISTORY AND PHYSICAL EXAMINATION

NAME: FITZWATER, JACKIE L
UNIT #: D000038770

(Continued)

PLAN: We are going to admit him at this time. We are going to transfuse him with a total of 3 units with diuresis afterwards. Once his H&H has stabilized we will consider a continuous Furosemide drip. He is going to have 2.5 of Coumadin given tonight because of his coagulopathy and will monitor him closely on a daily basis his pro times. Reinstitute Coumadin and Lovenox as necessary as it returns back down to normal.

Lynn N. Smith, M.D.

D: 07/06/06 1713
T: 07/06/06 1717
WKG

cc:

PMT, Inc. Job #: 23727

RECEIVED JUL 10 2006



VALLEY MEDICAL ASSOCIATES, INC.



Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

HC 70, Box 16 (Rt. 92)
White Sulphur Springs, WV 24986
(304) 536-1014

CLINIC NOTE RICHARD R. DURHAM, D.O.

NAME: Jackie Fitzwater

DATE: 8-25-99

HISTORY: Mr. Fitzwater is here in Dr. Smith's absence. He is a sixty-two year old male who has PUD, coal workers pneumoconiosis, thyroid disease, previous cellulitis of the left lower extremity, aortic stenosis, S/P valve replacement with a mechanical valve, post-op Afib, was cardioverted, Type II diabetes, and obstructive sleep apnea. He is here today for follow up and for the last four to five days he has had some increased dyspnea, no cough, no fever. He has had some occasional tachycardia. He has been started on Rythmol and his irregular heart rate is improved. He has had some lower extremity edema which was worse four days ago and some mild redness in his right leg, but is clear now. His weight is increased four pounds. He has not been very compliant with his diuretics.

MEDICATIONS: Currently include Rythmol 150mg tid, Synthroid .15 qd, Prilosec 20mg qd, KCL 10 qd, Lasix 80mg bid, Warfarin 7mg qd, Paxil 20mg qd, Combivent inhaler two puffs q4h, Nasarel steroid inhaler, Fibercon and CPAP 11 cm. of water pressure with 2 liters of O2.

PHYSICAL EXAMINATION: BP: 120/70. P: 76. R: 20. Afebrile. Wt: 246. He is generally alert, appears to be in no apparent distress. Skin is warm and dry. HEENT: EOMI. PERLA. Neck: No JVD. Heart is regular, S1 and S2, without murmur or gallop. Lungs: Decreased breath sound of the bases, worse on the right than the left. Abdomen: Soft, non-tender, without mass, organomegaly or bruits. Bowel sounds are present in all four quadrants. Ext: 1+ pitting edema in both lower extremities. Pulses are symmetrical in upper and lower extremities. Neuro is non-focal.

ASSESSMENT: He is a sixty-two year old male who has a history of aortic valve replacement, currently anticoagulated, PUD, coal workers pneumoconiosis, thyroid disease, previous cellulitis of his lower extremity, post-operative Atrial Fib. currently in a sinus rhythm, Type II Diabetes and obstructive sleep apnea currently compliant with his CPAP and home O2. Mr. Fitzwater has progressive dyspnea with some dyspnea on exertion and lower extremity edema.

RECOMMENDATIONS: 1. He is to have a PA & Lateral chest x-ray which shows some questionable CHF and he does have a new right pleural fusion. 2. He is to have a

Jackie Fitzwater

Page 2

August 25, 1999

ambulatory oximeter study which was done on room air. He started at 89% and dropped to 86% on 2 liters. 3. He will be set up on O2 2 liters nasal cannula at home on a continuous basis with an ambulatory setup and conserver. 4. He is to have a baseline EKG which was done and shows a normal sinus rhythm, poor airway progression, inverted Ts inferior lateral which are old, no acute changes. 5. He will have a basic metabolic panel, Protima, INR. 6. He will follow up in one week with his primary care physician, Dr. Smith. He is strongly encouraged to be compliant with his diuretics and to take his diuretic as prescribed and he is to watch his salt intake.


Richard R. Durham, D.O.

RRD/pab

T: 8-30-99

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

8/31/99246132/80- P-809 52% → 85%

Need Rx's
for Papil & Valvular

Jackie Fitzwater

8-31-99

L. Smith, M.D.

S: Jackie was seen last week by Dr. Durham, he was having the onset of some SOB. Evidently he was hypoxic, was started on some O2 and had what appeared to be at least by history an effusion. He took an extra fluid pill but I don't have any of the dictation back and Dr. Durham is not here to correlate exactly the problems. He denies any chest pain. He has not had any pleuritic type pains. NO acute onset of SOB, this was really chronic or sort of insidious in its onset. He denies any change in his legs or swelling which would make it suggestive of a DVT. He is on chronic anticoagulation therapy because of his prosthetic valve and he has not had any worsening palpitations. He has not had any recurrence of his atrial fib.

PMH: He has known Black Lung disease. He has a history of diabetes and a history of valvular replacement due to rheumatic heart disease.

O: On exam today his BP is good. He is not tachypneic and his pulse is 60 at rest. He has no real audible wheezes, rales or rubs. His valve click is the same with no new diastolic murmur. He has about 1+ edema which is unchanged. Liver is not enlarged. Ambulatory oximetry does drop from about 95 to 85% and he does get dyspneic.

A: IMPRESSION:

1. Exercise induced hypoxia, questionable effusion.

Jackie Fitzwater

8-31-99

L. Smith, M.D.

Confirmed...

P: We are going to recheck his CXR at this time including a lateral decubitus if an effusion is present. He is going to increase his Coumadin up to 8 mg a day as his INR is only 2.5 which is not adequate for his valve. His electrolytes, etc., and blood sugars were normal last week. We are going to bring him back next week for a check up but we will call him with a results of his labs. T: 9-1-99/crw



VALLEY MEDICAL ASSOCIATES, INC.



Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

HC 70, Box 16 (Rt. 92)
White Sulphur Springs, WV 24986
(304) 536-1014

CLINIC NOTE

RICHARD R. DURHAM, D.O.

NAME: Jackie Fitzwater

DATE: 9-23-99

HISTORY: Mr. Fitzwater is a sixty-two year old male with peptic ulcer disease, coal workers pneumoconiosis, thyroid disease, previous cellulitis of his lower extremity, aortic stenosis, S/P AVR, post op a-fib, cardioverter, type II diabetes and obstructive sleep apnea. Mr. Fitzwater was seen by myself on August 25, 1999 and was found to have a right pleural effusion and has not been very compliant with his diuretics. He was told to take his diuretics as prescribed. He was placed on some O2 during the day. He has had a repeat chest x-ray which shows the effusion to be relatively stable. It does layer out on lateral view and a recent echo is unremarkable. His weight has gone up four pounds in the last week.

MEDICATIONS: Currently include O2 2 liters nasal cannula, Warfarin 8mg qd, Rythmol 150mg bid, Synthroid .15 qd, Prilosec 20mg qd, KCL 10 qd, Lasix 80mg bid, Paxil 20mg qd, Combivent two puffs q4h, Nasarel steroid inhaler, Fibercon, CPAP 11 cm. of water pressure with 2 liters of O2.

PHYSICAL EXAMINATION: BP: 120/80. P: 80. R: 18. Afebrile. WT: 262. He is generally alert, in no apparent distress. Skin is warm and dry. HEENT: EOMI PERLA. NECK: No JVD. HEART: Regular, S1 and S2, without murmur or gallop. LUNGS: Decreased breath sounds on the right base 1/3 of the way up with a percussion /3 of the way up. ABDOMEN is obese, soft, non-tender, without mass, organomegaly or bruits. Bowel sounds are present in all four quadrants. EXT: 2+ pitting edema in both lower extremities. NEURO: Grossly non-focal.

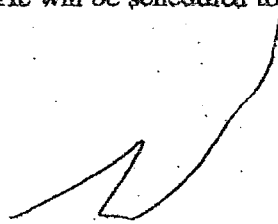
ASSESSMENT: He is a sixty-two year old male who has aortic valve replaced with a right pleural effusion. The chest x-ray certainly looks like he has some mild congestive changes and the pleural effusion is most likely is secondary to congestive changes, however his echo has been read as being relatively normal. He does have a history of coal workers pneumoconiosis, PUD, thyroid disease, post op a-fib, type II diabetes and sleep apnea.

Jackie Fitzwater

Page 2

September 23, 1999

RECOMMENDATIONS: 1. I will review his chest x-rays with the radiologist at the hospital. 2. He will have an ambulatory oximeter study. He started at 92% and went to 91%. We will consider possible thoracentesis, which could be somewhat of a high-risk procedure secondary to his anticoagulation with an INR of 3.5 presently. 3. He will be scheduled to follow up in two weeks.



Richard R. Durham, D.O.

RRD/pab
T: 10-2-99



VALLEY MEDICAL ASSOCIATES, INC.



Rt. 2, Box 171
Lewisburg, WV 24901
(304) 645-3207

HC 70, Box 16 (Rt. 92)
White Sulphur Springs, WV 24986
(304) 536-1014

CLINIC NOTE
RICHARD R. DURHAM, D.O.

NAME: Jackie Fitzwater

DATE: 10-6-99

HISTORY: He is a 63-year old male with peptic ulcer disease, coal worker's pneumoconiosis, thyroid disease, previous cellulitis of his lower extremities, aortic stenosis S/P AVR, postop atrial fibrillation, cardioverted, type II diabetes and obstructive sleep apnea. He is here today for follow-up. He has had a persistent right pleural effusion. He has had increasing dyspnea.


MEDICATIONS: Currently include Cardizem CD 120 q daily, Rythmol 150 bid, Synthroid .15 qd, Prilosec 20 q daily, KCL 10 qd, Lasix 80 bid, Warfarin 8 mg q daily, Paxil 20 q daily, Combivent inhaler 2 puffs q-4, Nasarel steroid inhaler, FiberCon, CPAP 11 cm water pressure with 2 liters of O2.

PHYSICAL EXAMINATION: BP: 124/72, P: 80, R: 24, T: 97.7, WT: 268, which is up 22# from his visit on 8/25/99. He is generally alert, in no apparent distress. Skin is warm and dry. HEENT: EOML PERLA. NECK - no JVD, bruits or adenopathy. HEART: Regular, S1 and S2, without murmur or gallop. LUNGS - decreased breath sounds with dullness to percussion in the right base 1/3 of the way up. ABDOMEN is obese, soft, non-tender, without mass, organomegaly or bruits. Bowel sounds are present in all four quadrants. EXT: 2+ pitting edema both lower extremities. NEURO: Non-focal.

ASSESSMENT: He is a 63-year old male with persistent right pleural effusion with chronic dyspnea, peptic ulcer disease, coal worker's pneumoconiosis, thyroid disease, aortic valve replacement, postop atrial fibrillation, type II diabetes, sleep apnea, pulmonary hypertension and possible diastolic dysfunction.

RECOMMENDATIONS:

1. He will be sent to the Outpatient Surgical Department and he will undergo thoracentesis. He will have a protine and an INR drawn there and he is to have PA and lateral CXR which was done today and shows increase in his effusion.
2. He will follow-up in one week.


Richard R. Durham, D.O.

RRD/crw
T: 10-13-99

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

V up
need vit B-12 IM

6/3/98 251 120/72 74

CHA

B-12 IM given @ 2pm CHA
RBB 12mg ldl

Jackie Fitzwater

6/3/98

L. N. Smith, M.D.

S: Jackie comes in just for his check up. His sugars have been doing well. His neuropathy symptoms have been doing well. He doesn't do well with the heat. He has a lot more shortness of breath and some nausea when he tries to become physically active. A lot of this is related to his size and we've again stressed the fact that he needs to have weight loss, both for his diabetes as well as for his sleep apnea.

O: On examination today, his blood pressure is good. Lung fields are clear. Cardiac is unremarkable. His peripheral edema is trace and still under good control. His two hour post prandial sugar is 121.

A: 1. Sleep apnea. 2. Peripheral neuropathy post inflammatory. 3. Diabetes Type II, obese, on oral agents.

P: 1. No change in his medical management at this time.

2. We've given him further dietary information to try to get this gentleman to lose some weight.

3. He is going to have his B₁₂ shot given today for his pernicious anemia.

LNS/dll

PHONE MEMO	TO	Nurse	DATE	6/25	TIME	8:30 AM
	FROM	Jackie Fitzwater	AREA CODE			
	OF		NO.			
			EXT.			
MESSAGE	Inhaler - Combivent 2 puffs had 1 X - 40mg #60 2nd 2nd K - Dill 20mg #60 2nd 2nd Terminal Stage					
	SIGNED: [Signature]					
	PHONED	CALL BACK	RETURNED CALL	WANTS TO SEE YOU	WILL CALL AGAIN	WAS IN
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URGENT <input type="checkbox"/>						

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Rt. 2, Box 171
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PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

cc: pt finished Ceclor
Coughing, heart congested

5/7/98 252 130/74 76

Jackie Fitzwater

5-7-98

L. Smith

S: Jackie called in a week ago with a productive cough. He was put on a dose of Ceclor, but it's not cleared. He's still having a lot of SOB, wheezing, cough, with a yellow-green sputum production. He's had some low grade fevers with this as well.

O: His lungs shows some expiratory wheezing with scattered rhonchi throughout. He's in no respiratory distress. No significant peripheral edema and no JVD. Chest x-ray shows findings consistent with a bronchitis without evidence of any active infiltrate.

A: 1. Bronchitis with bronchospastic lung disease

P: We will put him on a 20 mg taper of Prednisone at this time. He is also going to start on Levaquin 500 mg once per day.

A sputum has been obtained for gram stain and CNS. I have given him enough samples for 4 days and he'll contact us at that time for his culture results.

LNS/srs

5-13-98. pt called re results 2 3:30

5/24/98 Glucocort 5mg #30 - 5mg
called to Terminal 1



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History and Physical Examination L. N. Smith, M.D.

Jackie Fitzwater

1-15-98

HISTORY OF PRESENT ILLNESS: Jackie is in today for a physical examination. This gentleman has multiple problems. We have difficulty trying to keep track of them unless we summarize periodically. He has recently had some mild congestion, had an upper respiratory it's been clear with some mild increased shortness of breath and increased mucous during this time frame but overall during the winter has done fairly well.

PAST MEDICAL HISTORY: His past medical history is significant for the following: 1. Hypothyroidism. 2. Sleep apnea. 3. Carpal tunnel syndrome. 4. Aortic stenosis. 5. B12 deficiency. 6. Diabetes mellitus Type II, obese. 7. Post inflammatory neuropathy. 8. Chronic gastritis. 9. Chronic obstructive lung disease.

PAST SURGICAL HISTORY: cholecystectomy.

FAMILY HISTORY: Mother died at 78 of cardiac origin. Father died at 76 of old age. He has one brother that is alive that has multiple problems most of which have been injuries.

SOCIAL HISTORY: He's married, he has 2 children. He is a retired coal miner of 40+ years. He has cigarettes of better than a 40 pack year history and is still smoking at least one pack of cigarettes per day. No significant alcohol.

ALLERGIES: None known.

MEDICATIONS: Synthroid .15 qd, Lasix 80 mg qd, Glucotrol 5 mg qd, Serevent 2 puffs b.i.d., Prilosec 20 mg b.i.d., Propulsid 10 mg t.i.d. He uses Carafate and Soma on a prn basis.

REVIEW OF SYSTEMS: He still has some numbness in his left hand. He is due for a carpal tunnel release in the very near future. His bowels have been regular. No GU symptoms. He has recently had an endoscopy and is on therapy for his severe gastritis.

EXAMINATION: Her exam shows a weight of 247, BP: 120/70, P: 78.

HEENT:

Pupils are equal and reactive. Fundoscopic exam is normal showing no evidence of diabetic change.

NECK:

Good carotid upstrokes. He has a transmitted murmur audible in his neck. Cannot discern any bruits. Thyroid is not enlarged.

LUNGS:

Lung fields are clear except for some forced expiratory wheezing and some scattered rhonchi in the left.

Jackie Fitzwater
L. N. Smith, M.D.
Page 2
History and Physical

Cardiac: Regular rate rhythm, grade 3/6 systolic ejection murmur heard best, second right intracostal space and second left, radiates into the carotids and across the precordium.

ABDOMEN: Significantly obese. Bowel sounds are active. He has no organomegaly or palpable tenderness.

PELVIC/RECTAL: Prostate is 1+ enlarged. Stool is hem negative. He has some external hemorrhoids.

EXTREMITIES: He has trace peripheral edema. Pulses are adequate. He has decreased sensory in both legs, right much worse than left. He has a dense sensory loss in the right leg from the mid thigh down.

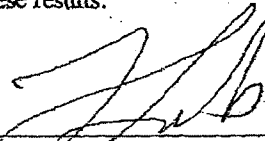
NEURO: Cranial nerves within normal limits. DTR's are absent in his ankles and absent in his right knee. His gait is normal. He has a positive Homans with a tendency to fall to the right. He has difficulty with tandem gait but is capable of performing it.

SKIN: He has evidence of some seborrheic dermatitis on his face.

Impression:

1. Aortic stenosis. 2. Diabetes Type II. 3. Peripheral neuropathy, partly diabetic and partially post inflammatory. 4. B12 deficiency. 5. Carpal tunnel syndrome. 6. Hypothyroidism. 7. Sleep apnea. 8. COPD.

PLAN: At this time he's going to have his routine labs including HgbA1C level, urinalysis, stool hemoccults, PSA will be drawn. A chest x-ray will be obtained. He's had an echocardiogram within the last 6 months and has measured his valve velocities which are adequate at this time. He is going to have these performed and will return in approximately 2 weeks to go over these results.



L. N. Smith, M.D.

LNS/kls
T: 1-16-98

Jackie
Fitzwater
1/15/98

VALLEY MEDICAL ASSOCIATES, INC.
Rt. 2, Box 171
Lewisburg, WV 24901

Patient Profile: Physical

Chief Complaint:

History of present illness: C/O congestion - some SOB -
it mucus - recent cold -

C/A

Age - 61

Past Medical History:

Allergies NKDA

Hospitalizations and Surgery - GP

Medications

Chronic illness

HBP
D.M.
COPD+
Heart Disease -
Arthritis

UTI
bowel habit changes
weight change
back problems
joint pains

Ⓢ shoulder Bony

number of children - 2
Occupation - Retired mines - 40 yr TB -
Student

✓med list Hypothroid
Sleep Apnea
CTS (B)
Aortic Stenosis
B12 def.
Not inflm neuropathy
Gastritis

Drn - IT

COPD.

TH

↓ m78 - CACD
↓ 776 dd 4n

Review of Systems

Menses
Headaches
Sinus/allergy
cough
palpitations
chest pain

Social History

Married
Single
Divorced

Cigarettes yes 1 1/2 pk
x 40 yr
ETOH -

Physical Exam WT. 247 BP. 120/70 TPR 98

HEENT: NCAT EOMI PERLA CS Fundi

Neck: Supple JVD T4 ⊕ adenopathy ⊕

Carotid bruits

Breasts:

Lungs: ⊕ T4 J3 em.

Heart:

Abdomen:

Extr:

Trace edema

Genitalia: nee

Rectal: fl prot

Assessment and Plan:

**VALLEY MEDICAL ASSOCIATES, INC.**

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(304) 536-1014

HISTORY AND PHYSICAL EXAMINATION
RICHARD R. DURHAM, D.O.

NAME: Jackie Fitzwater

DATE: 3-26-99

REFERRING PHYSICIAN: Lynn N. Smith, M.D.
(referred for chronic dyspnea and desaturations)

HISTORY: He is a 62-year old male who has had some dyspnea off and on for the last two years, has been increased in the last 2 months after he has had some valvular heart surgery. He has DOE when walking approximately 50 - 75' without associated chest pain. He does have a cough with occasional white sputum. He has occasional wheezing, no hemoptysis, no weight loss. He is maintained on CPAP therapy and we're not sure of the pressures. He has no somnolence. No significant snoring, no memory changes. No irritability. No a.m. headaches, maintained on a CPAP machine.

PAST MEDICAL HISTORY: Significant for peptic ulcer disease, coal-workers pneumoconiosis by history, hypothyroidism. He had a cellulitis of his right lower extremity with aggressive Strep infection. He has had significant aortic stenosis and he has had a mechanical valve replacement in the last two months. He had postop A. fibrillation and was DC cardioverted. He is currently in a sinus rhythm. He has type II diabetes mellitus, currently diet controlled and obstructive sleep apnea.

PAST SURGICAL HISTORY: Cholecystectomy, appendectomy, aortic valve replacement, bilateral carpal tunnel disease.

FAMILY HISTORY: Mother deceased at 78 with CAD, father deceased at 80 with old age. He has two brothers, one deceased, one sister deceased. One brother had meningitis. He is not sure what happened to his sister.

SOCIAL HISTORY: He is a 30+ pack year tobacco user, quit 5 months ago. No alcohol. He worked in the mines for 40 years, had significant dust exposure by history. He states that he got a payment for Black Lung on one occasion but does not receive monthly benefits. He has had no TB exposure.

ALLERGIES: NKDA.

MEDICATIONS: Currently include Synthroid .15 q daily, Prilosec 20 q daily, KCL 10 q daily, Lasix 80 q daily, Warfarin 5 mg q daily, Lanoxin .25 mg q daily, Combivent MDI 2 puffs q-4 pm, Paxil 20 q daily and Nasarel nasal inhaler.

REVIEW OF SYSTEMS: HEENT: He does wear glasses. He has some hearing deficits but he has had previous hearing tests with no gross abnormality being found. **CP: HPL** **GI:** he has had some hemorrhoids with occasional bleeding since he has been on Warfarin. No abdominal pain or melena.

GU: No hematuria, dysuria. **BONES/JOINTS:** he has some generalized aching in his joints. **NM:** he has bilateral carpal tunnel disease. **PSYCH:** Some mild anxiety secondary to recent heart surgery.

HEMATOLOGIC/ONCOLOGIC: Unremarkable. **SKIN:** No rash.

Jackie Fitzwater

Page 2.

PHYSICAL EXAMINATION: BP: 130/72, P: 86., R: 22, T: 97.9, Wt: 251. He is generally alert, in no apparent distress. Skin is warm and dry. HEENT: EOML PERLA. Fundi are benign. TM's are clear. Throat is unremarkable. Neck - no JVD, bruits or adenopathy. Heart is regular, S1 and S2, with a mechanical valve sound. Lungs - decreased breath sounds but clear. IE is 1:4. No wheeze. Abdomen is obese, soft, non-tender, without mass, organomegaly or bruits. Bowel sounds are present in all four quadrants. EXT: Trace edema both lower extremities. Neuro - non-focal.

ASSESSMENT: He is a 62-year old male with chronic dyspnea and DOE with a baseline history of peptic ulcer disease, coal-workers pneumoconiosis, hypothyroidism, previous cellulitis of his right lower extremity with some mild neuropathy, recent aortic valve replacement with a mechanical valve, currently anticoagulated, postop A. fibrillation DC cardioverted, currently in a sinus rhythm, Type II diabetes mellitus, diet controlled and obstructive sleep apnea maintained on CPAP pressures with improved symptomatology.

The etiologies of his chronic dyspnea and DOE are most likely secondary to his chronic tobacco abuse, deconditioning and being overweight.

RECOMMENDATIONS:

1. We will obtain pulmonary function studies which was done and shows a combined obstructive restrictive process of moderate severity.
2. We will obtain full pulmonary function studies in the hospital setting.
3. Due to his sleep apnea, he will have a recorded overnight oximeter study with CPAP.
4. He is to have an ambulatory oximeter study. He started at 92% and dropped to 85% on 6-minute walk. Again he will have the full pulmonary function studies and will follow-up after these are done and we will make further recommendations at that time.

I am concerned about the restrictive nature of his pulmonary function studies. We do have a CXR which shows some chronic changes and this was done in the hospital setting as well as a blood gas which was done on room air, pH of 7.46, PCO2 of 44, PO2 of 65.



Richard R. Durham, D.O.

T: 4-1-99
RRD/crw

Valley Medical Associates, Inc.

Rt 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME: Jackie Fitzwater

DATE 1/24/97 WT 241 BP 124/80 PULSE 88 CC: URT
cough

Fitzwater, Jackie

11-24-97

L. N. Smith, M.D.

S: Jackie comes in with complaints of cough, congestion, sweating episodes. He's been having a brownish sputum production over the last 48 hours. Minimal upper respiratory symptoms as far as nasal congestion, etc., but most has been pulmonary in origin.

O: Today he has very congested cough. He has scattered rhonchi throughout, prolonged expiratory phase with wheezing. He has no tender nodes. He does not appear in any respiratory distress.

A: Impression: 1. Bronchitis/pneumonitis. 2. Bronchospastic lung disease with exacerbation.

P: We're going to start him on *Sepra DS* b.i.d. Sputum has been obtained for culture. We will also start him on *Prednisone* 20 mg and a taper. Close observation over the next 48 hours to watch for high fever, shaky chills, some other evidence of tissue invasion that would x-ray investigation. He will contact us if he shows any signs of worsening.
LNS/kl

12-8-97

Terminal

Lasix 40mg T qd #30

K-Dur 20mg i BID #60 3 RFS

per LNS/cg

PHONE CALL			
FOR <u>Nurse</u>	DATE <u>12-8</u>	TIME <u>1:50</u>	P.M.
M	<u>Terminal</u>		
OF <u>Jack Fitzwater</u>			
PHONE <input type="checkbox"/> FAX <input type="checkbox"/> MOBILE <input type="checkbox"/>	<u>438-6633</u>		
AREA CODE	NUMBER	EXTENSION	
MESSAGE			
<u>40 mds mds.</u>			
<u>Lasix 40mg T qd</u>			
<u>per K-Dur 20mg i BID</u>			
SIGNED <u>per</u>	FORM 4003		

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

4-18-97

252

120/70

76

fallen up

FBS: 97 mg/dL

Jackie Fitzwater

4-18-97

L. Smith, M.D.

S: Jackie comes in today. He is having problems with his right knee. It tends to give way on him. He has a lot of pain with it. He can't get down and get back up. No history of any recent injuries to it but he has had severe neuropathy which is a contributing factor. His breathing is much improved. His ~~bronchospasm~~ is pretty well cleared.

O: Today on exam he has minimal wheezing on forced expiration but good aeration. A little too much edema, it is up about 1+ on both legs. He has some tenderness in the medial ligaments on his right knee. Negative shelf and no real swelling.

A: Impression:

1. Bronchospastic lung disease, improved.
2. Peripheral neuropathy.
3. Right knee pain.

P: We will get an x-ray of the knee to rule out any degenerative change. We will keep him on the Serevent two puffs bid, Humibid LA two tablets bid as a mucolytic agent. He is going to follow-up in about 2 weeks to have some skin lesions removed and we will go over his x-rays and re-evaluate his knees at that time. LNS/crw

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
Davis Stuart Road
Lewisburg, WV 24901
(304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

4/4/97

250

130/72

78

needs script
✓ 40, 100, 300 of
chest pills full

CH

RBS - 116 mg/dl

B-12 given 4m

Jackie Fitzwater

4-4-97

L. Smith, M.D.

S: Jackie has had a cough over the last week, sputum production. He has had one episode that he thought was a low sugar reaction. He got real weak, dizzy, had to sit down for awhile. Sugars have been running pretty good. The Neurontin did make a major improvement in the leg, not as far as affecting the paraesthesias but the pain is much better. The burning neuropathic pain is improved on this lower dose of the Neurontin.

O: Today he has a very congested wheezing bilaterally, forced expiratory wheeze and congested cough with purulent sputum. No other consolidated areas are identified. His sugar is good at 119 post prandially.

A: Impression:

1. Bronchitis with bronchospasm.
2. Severe peripheral neuropathy.
3. Diabetes mellitus.

P: We are going to keep his other medicines the same, put him on Ceclor 250 mg tid. Serevent 2 puffs bid. He is going to continue being monitored for his routine care. Continue monitoring his sugars at home. LNS/crw

VALLEY MEDICAL ASSOCIATES, INC.

Rt. 2, Box 171
 Davis Stuart Road
 Lewisburg, WV 24901
 (304) 645-3207

PATIENT NAME:

Jackie Fitzwater

DATE

WT

BP

PULSE

CC:

*12-11-96**150mg**150mg**#30**- 8d - 2LF**Terminal Drug**20 3:00*

Jackie Fitzwater

12-11-96

Dr. L. Smith

S: Jackie comes in today. He is having a cough, upper respiratory, productive sputum, sinus drainage, a little more SOB. The Effexor though has helped his leg. He thinks that it has made a big difference in the amount of pain that he has had.

O: H is exam does show some upper airway rhonchi, maxillary tenderness. He has a very congested cough.

A: Impression: 1. Bronchitis.
 2. Peripheral neuropathy.

P: We are going to increase his Effexor up to 37.5 mg bid. We are going to put him on Amoxil 500 mg tid, #21, one refill. He is going to watch and make sure that his upper respiratory completely clears and will contact me after he has been on this higher dose for a couple of weeks to make sure he is tolerating it. I have given him a scrip for #60 and two refills so that he can stay on the medication. LNS/crw

PHONE CALL

FOR	<i>Nurse</i>	DATE	<i>12/30</i>	TIME	A.M. P.M.
M.	<i>Jackie Fitzwater</i>				
OF					
PHONE	<input type="checkbox"/> FAX				
	<input type="checkbox"/> MOBILE				
MESSAGE	AREA CODE	NUMBER	EXTENSION		
<i>Terminal Drug</i>					
<i>K-Dur 20mg #60 REXS</i>					
<i>per LNS/CHA</i>					
SIGNED					

FORM 4009

BP

Jackie Fitzwater

6/13/96

CC

WT 259 BP 122/70

P 84

CC

Jackie Fitzwater

6-13-96

Dr. L. Smith

S: Jackie comes in today. He is due for a recheck on his liver tests. He is having cough with yellowish sputum production. He is due for a Tegretol level. He still has his neuropathic pain which has been really refractory to any type of treatment that we have done so far. He is going to have that medicine adjusted by Dr. Dawson in Roanoke, his neurologist.

Jackie Fitzwater continued...

O: His exam today shows his lungs are clear. Cardiac is unchanged. His edema is under good control.

A: Impression: 1. Diabetes.
2. Peripheral neuropathy, post injury.
3. COPD.
4. Bronchitis.

P: I am going to get a sputum for Gram stain, C & S, start him on Cedax one tablet a day for the next 4 days, samples were given. He is going to have his routine blood work drawn at this time with copies sent to his neurologist. He is going to contact us the first of the week by phone for follow-up. LNS/crw

7/9/96 WT 259

BP 120/72

P 80

CC Flt
Constipated
took otc laxid
now has diarrhea

Jackie Fitzwater

7-9-96

Dr. L. Smith

S: Jackie evidently had some obstipation problems, took some Dulcolax tablets and now has some diarrhea this morning. He has actually felt fine, the bloating and the discomfort is all resolved. He had no nausea, or vomiting and has had no change in his overall stool consistency. His bowels usually work quite well.

O: His exam today shows no findings. ABD is soft, normoactive bowel sounds. NO tenderness or distention.

A: Impression: 1. Obstipation.

P: I have asked him to start on some FiberCon tablets, two at hs with an 8 ounce glass of water. He will contact me if he has any further symptoms. LNS/crw

HUMANA HOSPITAL GREENBRIER VALLEY
ROUTE 219 SOUTH DAVIS-STEWART ROAD
FAIRLEY, WEST VIRGINIA 24902

Name fitzwater, jackie l.
ID 2364750
Date 02-28-1991
Physician SMITH, L.
Diagnosis RESP. ABNORM.

Height 70 inches
Weight 219 lbs
Age 54 years
Sex Male
Race White

		Prebronchodilator Actual	Percent	Predict	Postbronchodilator Actual	Percent	Percent Change
FVC	(L)	3.55	82	4.34	3.42	79	-4
FEV-1	(L)	2.79	82	3.39	2.66	79	-5
FEV-1/FVC	(%)	79		78	78		-1
PEFR	(L/S)	5.66	67	8.39	7.56	90	34
FEF25-75	(L/S)	2.61	64	4.10	2.28	56	-13
EXP TIME	(S)	6.35			5.58		-12
FIVC	(L)	1.52			3.62		137
PIFR	(L/S)	1.65	42	3.90	3.04	78	85
FIF50/FEF50		0.46	47	0.97	0.87	90	91
MVV	(L/M)	135	91	149			
SVC	(L)	4.01	92	4.34			
ERV	(L)	0.61					
IC	(L)	3.40					
RV	(L)	1.72	98	1.76			
FRC	(L)	2.33	85	2.75			
TLC	(L)	5.73	87	6.57			
RV/TLC	(%)	30		27			
FRC/TLC	(%)	41		42			
DLCO		28	111	26			
VA (STPD)	(L)	5.02					
DLCO/VA		5.67					
TLC (SB)	(L)	6.07					

>Standard Adult Normal Equations

Technical Comments

PT. TOL. WELL WITH GOOD EFFORT
0.5CC VENTOLIN AS BRONKODILATOR
R. MARKUM CRTT

Interpretation

The ratio of actual to the predicted FEF25-75 is 64% and suggestive of early small airways obstruction. Additionally, the results indicate that the DLCO is normal. There is no significant improvement in results after the administration of a bronchodilator.

Jackie Fitzwater

OT 255

BP 130/90 P 76
05-12-95

cc follow up

RBS - 120

Jackie Fitzwater
5-12-95

Dr. Smith

S: Mr. Fitzwater got a CPAP at home, seems to be doing better. He is still having his chronic leg pain. This gentleman has neuropathic pain which I believe is post inflammatory. He is on no therapy at this time, has been fully evaluated at Charlottesville, Rheumatology, etc. They really don't have anything else to offer except symptomatic care in this gentleman. He has had elevated liver functions and electrolyte disturbances due to the diuretic. However, further investigation of this may be necessary.

O: His exam today: Lung fields are clear, liver is not enlarged but he is significantly obese and the exam is quite limited. He does still have his 2+ pitting edema of his leg and the dysaesthesia.

Plan: To recheck his electrolytes and liver functions at this time. We will start him on Tegretol 50 mg bid, continue with his other medications. He is going to contact us in a week for dosage adjustment and determine whether we need to pursue possible liver biopsy.

05-19-95

WT 258 BP 126/84 P 88 a F/U
1/2 hr pp BS - 149

leg pain

JACKIE FITZWATER

LYNN SMITH, M.D.

S: JACKIE'S LEG HAS IMPROVED. HAS NOT COMPLETELY RESOLVED BUT HE HAS NOTED SOME IMPROVEMENT WITH THE TEGRETOL. HE IS TOLERATING THE CPAP FAIRLY WELL. HIS BS HAS BEEN UNDER GOOD CONTROL. HE HAS BEEN TRYING TO STICK TO HIS DIET AND LOOSE SOME WEIGHT.

O: EXAM IS UNCHANGED. NO NEW PHYSICAL FINDINGS.

A: GLUCOSE INTOLERANCE

POST INFLAMMATORY NEUROPATHY

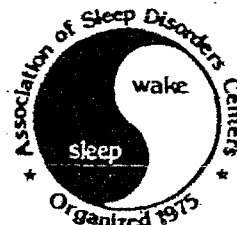
P: INCREASE HIM TO 100 PER DAY ON THE TEGRETOL. HE WILL COME BACK IN 3-4 WEEKS. HE ALSO HAS A NUMBER OF WARTS THAT WE WILL FREEZE ON HIS SCALP THAT ARE SYMPTOMATICALLY GIVING HIM SOME TROUBLE. HE IS ADVISED OF THE RISKS AND THE SIDE EFFECTS OF THE TEGRETOL AND THE POSSIBILITY OF MARROW SUPPRESSION. HE WILL FOLLOW UP VERY CLOSELY FOR ROUTINE CBC'S.



Caring For Life.

THE SLEEP DISORDERS CENTER
COMMUNITY HOSPITAL OF ROANOKE VALLEY

(703) 985-8526



ACCREDITED CENTER

POLYSOMNOGRAM RESULTS

PATIENT: Jackie L. Fitzwater

MEDICAL RECORD NUMBER: 6315543

463569

AGE: 59

SEX: Male

DATE: 05-03-95

	MINUTES	%		REM	NREM
RECORDING	385		TYPICAL LENGTH OF RESPIRATORY EVENT	11 sec	15 sec
WAKEFULNESS	101.3		MAXIMUM LENGTH OF RESPIRATORY EVENTS	19 sec	31 sec
TOTAL SLEEP TIME (TST)	282.2	73.3	NUMBER OF HYPOPNEAS	9	31
STAGE 1	13.9	(%TST) 4.9	NUMBER OF OBSTRUCTIVE AND MIXED APNEAS	9	16
STAGE 2	225	79.8	NO. OF CENTRAL APNEAS	—	2
STAGE 3	1.0	0.4	LOWEST O2 SATURATION %	74	82
STAGE 4	—	—	RESPIRATORY DISTURBANCE INDEX	39/hr.	
REM	42.2	15.0	TOTAL PERIODIC LEG MOVEMENTS IN SLEEP (PLMS)	2	
SLEEP LATENCY (MINUTES)		15.4	TOTAL PLMS WITH AROUSAL	1	
REM LATENCY (MINUTES)		120.2	TOTAL PLMS WITH AWAKENING	1	
TOTAL NUMBER OF AWAKENINGS		18			
AWAKENING > 2 MINS.		7			

PARAMETERS MONITORED:

EEG, EOG, ECG, EMG, (chin) R/L Anterior Tibialis EMG, Nasal/Oral Airflow, Respiratory Effort, O2 Saturation

COMMENTS: History of loud snoring. Hypersomnolence and chronic fatigue. Witnessed apneic events by wife. peripheral edema and pulmonary hypertension. Medication Lasix, Levitren, Inderal, Potassium and Zantac. Height 5ft. 9in. Weight 254. P.M. blood pressure 120/64, A.M. 110/70. The baseline oxygen saturation was 93%. Sleep onset occurred after 15 minutes. Moderate snoring, obstructive apneas, hypopneas and a hypoventilation pattern developed after sleep onset with oxygen saturation falling to 74% in REM and 82% in NON-REM. Due to this pattern which seemed clearly established he was placed on CPAP using a medium/wide mask, comfort flap, #4 spacer. He was titrated to a pressure of 8 cm water and later to 10 cm water when sleeping supine. A chin strap

PATIENT: Jackie Lee Fitzwater

DATE OF STUDY: 05-03-95

Comment Continued: applied to prevent a air leak from his mouth. Heart showed sinus rhythm with occasional isolated PVC and a rate of 54 to 74 bpm. Patient indicated that he slept better than usual on his morning questionnaire and did not awakened with a headache.

IMPRESSION:

1. Obstructive sleep apnea syndrome with respiratory disturbance index of 39 apneas and hypopneas per hour of sleep prior to application of CPAP. CPAP setting was 10 cm water pressure, ramp time 20 minutes, medium wide mask, #5 spacer and chin strap.
2. Obesity hypoventilation pattern.
3. Cardiac rhythm disturbance, isolated premature ventricular contractions.

Patient encouraged to obtain CPAP unit and begin immediate use.

WSE/dbk

cc: Dr. Lynn Smith

W. Elias
William S. Elias, M.D., FASDA

Jackie Fitzwater

WT 254

BP 120/80

P 80

u Nausea

04-07-95

Wed 5/3/95 8:30am - Sleep Study

JACKIE FITZWATER

DR. SMITH

S- Jackie comes in. The ZAROLYN just made him feel sick and nauseated. He felt very weak because of the intense amount of fluid he lost. Interesting, this gentleman's HGBA1C was 9 when he was checked in Charlottesville. Even his sugars have never been diagnosed greater than 140-150 here. It is obvious that he may be overtly diabetic.

At this time he will have a recheck of his electrolytes and HGBA1C level. We are going to get his sleep study performed which as evidently not been scheduled. He will just use his current medicines including LASIX 60 bid, POTASSIUM bid and his ZANTAC. We will contact him as soon as we have the results of these studies. We are still awaiting final reports from UVA on his rheumatological evaluation.

04-11-95

WT 258

BP 130/82

P 76

u fallwrf

RBS-197

Jackie Fitzwater
4-11-95

Dr. L. Smith

Jackie's Hgb. A1-C level is elevated at 7.5. Sugar fasting was 236. His potassium was very low at 2.3 and over the weekend we actually increased him up to 4 a day on his potassium.

At this time, he is having significant dryness in mouth, polyuria, polydipsia. Part of it is his diuretic but we have to believe that his new onset of diabetes is part of the problem.

Impression:

1. Diabetes type II, obese.
2. Elevated liver functions, questionable etiology.
3. Probable sleep apnea.
4. Chronic leg pain, secondary to neuropathic post inflammatory.

PLAN: We are going to get a liver ultrasound. He is going to start on Glucotrol XL 5 mg per day, 1500 calorie ADA diet is advised and instructions are given as well as diabetic educational material. We are going to consider having liver biopsy done on this gentleman pending results of his ultrasound. The rest of his complete workup through UVA was unremarkable.

GREENBRIER VALLEY MEDICAL CENTER
Ronceverte, WV

RADIOLOGY REPORT

NAME: FITZWATER, Jackie WARD NO: ER/330-1
REQUESTED BY: Dr. Stout/L. Smith. DATE REQUESTED: 07/01-02/94
EXAMINATION: Chest, abdomen AGE: 58 SEX: M
PERTINENT HISTORY: Cellulitis of leg
DATE FILM TAKEN: 07/01-02/94 FILM NO: 38246

CHEST X 2:

These films show no significance difference. There is some increase in the lung markings bilaterally which is chronic in nature. The cardiovascular silhouette is unremarkable.


ABDOMINAL SERIES:

There is a moderate amount of gas in the transverse colon with occasional air fluid levels here. This pattern suggests the so-called colon cutoff sign. This form of localized ileus while not specific may be seen in association with pancreatitis.

ULTRASOUND OF THE RIGHT LEG VENOUS SYSTEM (2-D AND DOPPLER STUDY):

A normal venous flow pattern was demonstrated from the level of the inguinal ligament to the distal portion of the popliteal vein. There was no evidence of DVT.

There were two rounded densities in the right inguinal area compatible with moderately enlarged lymph nodes.


C. Rose, M.D.

CR/lmc/5612J
D: 07/03/94
T: 07/04/94

Jackie Fitzwater

WT 239 1/2 BP 138/78 P 80

cc pain left wrist

2/4/92

JACKIE FITZWATER DR. SMITH 2-4-92

S- JACKIE HAS HAD INCREASING PAIN AND NUMBNESS IN HIS LEFT ARM. HE HAS KNOWN CARPAL TUNNEL SYNDROME THAT HE HAS IGNORED FOR THE PAST TWO YEARS. AS A RESULTS HE IS NOW TO THE POINT THAT HE IS HAVING ISCHEMIC PAIN WITH HIS LEFT NERVE.

O- HE HAS NO EVIDENCE OF ATROPHY. HE HAS MARKED TENDERNESS WITH JUST THE FINGER PALPATION OVER THE LEFT WRIST.

A- 1. ISCHEMIC NEUROPATHY SECONDARY TO CARPAL TUNNEL SYNDROME

P- WE WILL CONTACT HIS ORTHOPEDICS TO GET EMERGENCY SURGICAL DECOMPRESSION AS SOON AS POSSIBLE.

05-07-92

WT 238 1/2 BP 138/86 P 76

cc ? EKG

JACKIE FITZWATER DR. SMITH 5-7-92

S- JACKIE WAS UP AT HIS BLACK LUNG EXAMINATION AND WAS READY TO EXERCISE AND THEY SAW SOME CHANGES ON HIS CARDIOGRAM AND THEY REFERRED HIM BACK IN TODAY. HE HAS BEEN HAVING A LOT OF CHEST DISCOMFORT BUT HE IS HAVING TERRIBLE DYSPEPTIC PROBLEMS, BURPING, BELCHING, REFLUX. HE IS USING MAALOX 3-4 TIMES PER DAY. HE HAS HAD NO PRESSURE OR PAIN WITH EXERCISE. HE HAS HAD 1-2 EPISODES WHERE HE DOES GET DIAPHORETIC WITH IT.

O- LUNG AND HEART EXAM IS ESSENTIALLY UNCHANGED. HE DOES HAVE A GRADE 2-3 AORTIC SCLEROTIC MUMMUR WITH NO DIASTOLIC COMPONENT. THERE IS A QUESTIONABLE MIDSYSTOLIC CLICK AS WELL.

EKG DOES SHOW T-WAVE INVERSION 1-2 AND L WHICH HAS BEEN PRESENT IN TH EPAST.

A- 1. CHEST PAIN, PROBABLE GI

2. CARDIAC ABNORMALITY MUST R/O ISCHEMIA

P- WE WILL REPEAT HIS ECHO TO MAKE SURE THAT WE ARE NOT DEALING WITH A TIGHTER VALVE. WE WILL DO A STRESS THALLIUM. DISCONTINUE HIS LODINE AND START ON ZANTAC 150 BID. IF HIS CARDIAC WORKUP IS NEGATIVE THEN ENDOSCOPY WILL BE INDICATED.

Stress Thallium Wed. May 27 7:30 A.M.

Echo & Doppler Aortic Motions Fri. May 8 2:00 p.m.

5/27/92 Ceclor 250mg #21 4:00 P.M. (LRT)
Wait Ex. cme today.

6-22-92 Amoxicillin 250mg T.i.d x 7 days

7-8-92 Bacta C 150mg - R.D. #100 1RT

WT 222 BP 136/84 P 72
02-28-91

cc test results

JACKIE FITZWATER DR. SMITH 2-28-91

HIS PFT'S DO INDEED SHOW EVIDENCE OF DECREASE BY ABOUT 10 PERCENT. PO2 IS DOWN TO 67. FORCED VITAL CAPACITY HAS DROPPED BY 10 PERCENT AS WELL. ALL OF HIS OVERALL PULMONARY FUNCTIONS ARE DECREASED BY 10 PERCENT SINCE 1984. HIS OTHER REMAINING LAB WORK IS UNEVENTFUL. HE DOES HAVE SOME MILD HYPERLIPIDEMIA WITH ELEVATED TRIGLYCERIDES AND CHOLESTEROLS. HE HAS NOW BEEN STARTED ON A LOW CHOLESTEROL WEIGHT REDUCTION PROGRAM. HIS NEUROPATHY IS STILL A PROBLEM. DESPITE THE USE OF TRENTAL AND B12 HE STILL HAS BURNING DYSTHESIAS WHICH SEEM TO HAVE PROGRESSED.

IMP: PERIPHERAL NEUROPATHY

2. BLACK LUNG DISEASE

3. HYPERLIPIDEMIA

4. HYPOTHYROIDISM

PLAN: HE IS AT THIS TIME GOING TO START AMITRIPTYLINE 10 MG T.I.D. DISP #90 THREE REFILLS. HE IS ADVISED OF SEDATION AND OF DRY MOUTH. HE WILL FOLLOW UP IN ONE MONTH. FORM IS BEING FILLED OUT FOR HIS WORKER'S COMP AND HIS BLACK LUNG DISABILITY BENEFITS. COPIES OF HIS PFT'S, CHEST X-RAY WILL GO WITH THE REPORT. NO OTHER CHANGE IN MEDICAL MANAGEMENT AND HE WILL FOLLOW UP IN 1 MONTH.

3/28/91 WT 219 1/4 BP 144/104 P 84
RA 142/110
140/96 - repeat

cc J/u

Jackie Fitzwater Smith

Jackie has noted a substantial improvement in his symptoms with the use of the AMITRIPTYLINE. BP is still running elevated and he does continue to have peripheral edema which he notices now pretty much on a regular basis.

IMP: Mild hypertension
Peripheral neuropathy

PLAN: Continue with the AMITRIPTYLINE. Start on MAXIDE 1/2 tablet a day and he will follow-up in two weeks with multiple blood pressure readings.

4-5-91 Tolactin 400mg BID #60 LRF

7-5-91 Amitriptyline 10mg TID #100 LRF

Amoxicillin 250mg TID #21 NRF

HUMANA HOSPITAL-GREENBRIER VALLEY
Ronceverte, WV

RADIOLOGY REPORT

NAME: FITZWATER, Jackie

WARD NO: OP

REQUESTED BY: Dr. Lynn Smith

DATE REQUESTED: 6/16/87

EXAMINATION: Chest

AGE: 51

SEX: M

PERTINENT HISTORY: Routine chest

DATE FILM TAKEN: 6/16/87


FILM NO: 38246

CHEST: PA and lateral compared to previous study 20 May, 1985.

There are no significant interval changes. No cardiomegaly, infiltrates, vascular congestion or pleural effusions. The lung fields do appear to be mildly hyperinflated suggesting either clinical asthma and/or mild emphysema. This is unchanged from the previous study.

IMPRESSION:

NO SIGNIFICANT INTERVAL CHANGE. NO CARDIOMEGALY, INFILTRATES, VASCULAR CONGESTION OR EFFUSIONS. FINDINGS SUGGESTING MILD PULMONARY EMPHYSEMA AND/OR CLINICAL ASTHMA IS NOTED. INCIDENTALLY NOTED, THERE ARE MULTIPLE OLD RIGHT HEALED RIB FRACTURES IDENTIFIED.


Terry D. Lesko, M.D.

TDL/vh

7531D

D: 6/17/87

T: 6/17/87

WILKINSON PULMONARY LABORATORY, INC.
16 1/2 STANFORD ROAD
ECKLEY, WEST VIRGINIA 25801

FITZWATER, JACKIE L.
M 4-25-36
BOX 312
QUINWOOD, W. VA 25981
0236-56-5934
INS-UMU

GOL GAS AND ERGOMETRIC SUMMARY SHEET

3483, FITZWATER, JACKIE, 10-13-78

HT-INS 68 HT-LBS 184

METER	TEST 1	TEST 2	TEST 3		EXERCISE EXPECTED
GRADE	0.000	2.000	2.000	0.000	
	0.000	10.000	15.000	0.00	
AIR RATE		152.000	156.000	0.00	
SP RATE		26.000	28.000	0.000	
NUTE VOLUME		39.516	42.069	0.000	
DAL VOLUME		1.520	1.502	0.00	
TOTAL L/MIN		1.392	1.551	0.000	
PUL L/MIN		1.344	1.469	0.000	
V02		0.966	0.947	0.000	20-30
		28.394	27.127	0.000	
O2 RATIO		0.257	0.282	0.00	
VS (PCT) DS		0.390	0.424	0.000	
UPTAKE CC/KG/MIN		16.640	18.543	0.00	
/ O2MMHG		95.237	91.987	0.000	
4.02 GRAD MMHG		28.237	30.987	0.000	11-13
MMHG	7.460	7.430	7.410	0.000	7.4
MMHG	68.000	67.000	61.000	0.000	77-99
MMHG	37.000	39.500	42.000	0.000	38-44
SAT	0.000	87.200	85.000	0.000	94-97
	0.000	0.000	0.320	0.000	.4-.6
	0.000	0.000	27.944	0.000	
DICTION DLCO	0.000	0.000	29.725	0.000	
ONT-LIKE EFFECT %	4.146	0.000	0.000	0.000	
MAX O2 L/MIN	0.000	0.000	3.	0.000	
MAX O2 L/MIN	0.000	0.000	2.848	0.000	395

FITZWATER, JACKIE
01-3883

10-13-78

INTERPRETATION: This patient has been employed in the coal mining industry for 22 years, working primarily at the tippie. He states that he first noted effort dyspnea approximately 7-8 years ago. He has also had a chronic cough with occasional sputum production. He denied wheeze. He has smoked one-half pack of cigarettes daily for 6 years.

Ventilatory studies and maximum breathing capacity were normal. Intrapulmonary mixing was minimally impaired. Lung volumes were normal.

Resting arterial oxygen tension was minimally reduced. The pCO_2 was normal. There was no increase in "shunt-like" effect.

The patient underwent exercise on the treadmill at 1.5 mph at 0% grade, and 2.0 mph at 10 and 15% grades. The patient completed his exercise with considerable apparent difficulty. No further exercise was attempted because of the patient's heart rate. His total volume of ventilation was normal. His heart rate was moderately excessive and was 88% of the expected maximum heart rate. Intrapulmonary oxygen transfer was moderately impaired, and the patient was significantly hypoxic. The fractional CO uptake was minimally reduced. The steady state $DLCO$ was minimally reduced to 70% of expected.

This patient exhibited moderate impairment in oxygen transfer and an abnormal cardiovascular response with exercise.

This patient would appear to be capable of performing steady work at light work levels. A numerical estimate of the overall loss of functional capacity in this case would be placed in the neighborhood of 60%.


D. L. Rasmussen, M. D.